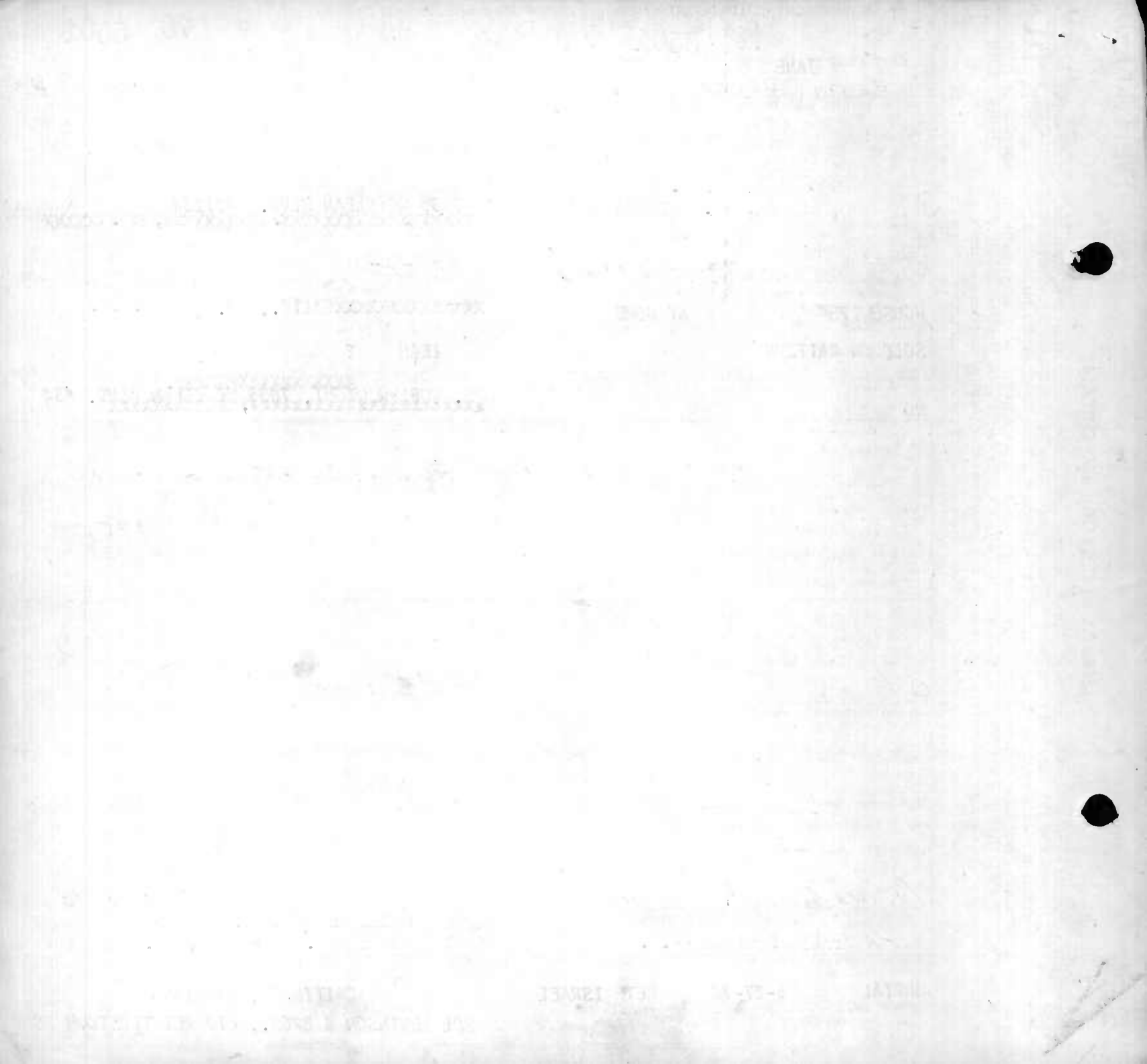


## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>JANE BETTY A DEWEN</b>		2. DATE AND HOUR OF DEATH <b>5/24/70</b> <b>3:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2737</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7033 MC CLEAN BLVD. #21234</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-30</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9. AGE (In years last birthday) <b>40</b>
11. BIRTHPLACE (State or foreign country) <b>XXXXXXXXXXXX BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SOLOMON RAITZYK</b>		14. MOTHER'S MAIDEN NAME <b>LEAH ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>XXXXXXXXXXXX</b>	
17. INFORMANT <b>MRS. ROSLYN WIGHT</b>		ADDRESS <b>7033 MC CLEAN BLVD. #34</b>	
18. <b>284X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Thrombocytopenic Purpura</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>aplastic Anemia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>1958</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO POST</b>	
20A. AUTOPSY? (Yes or No) <b>NO POST</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or out of home, farm, factory, street, office bldg., etc.) <b>IN</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/23</b> 19 <b>70</b> to <b>5/24</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Arnold Levinson</b> M.D.		23B. DATE SIGNED <b>5/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Arnold Levinson M.D.</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-27-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>BETH ISRAEL</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	





A-652

70 5502

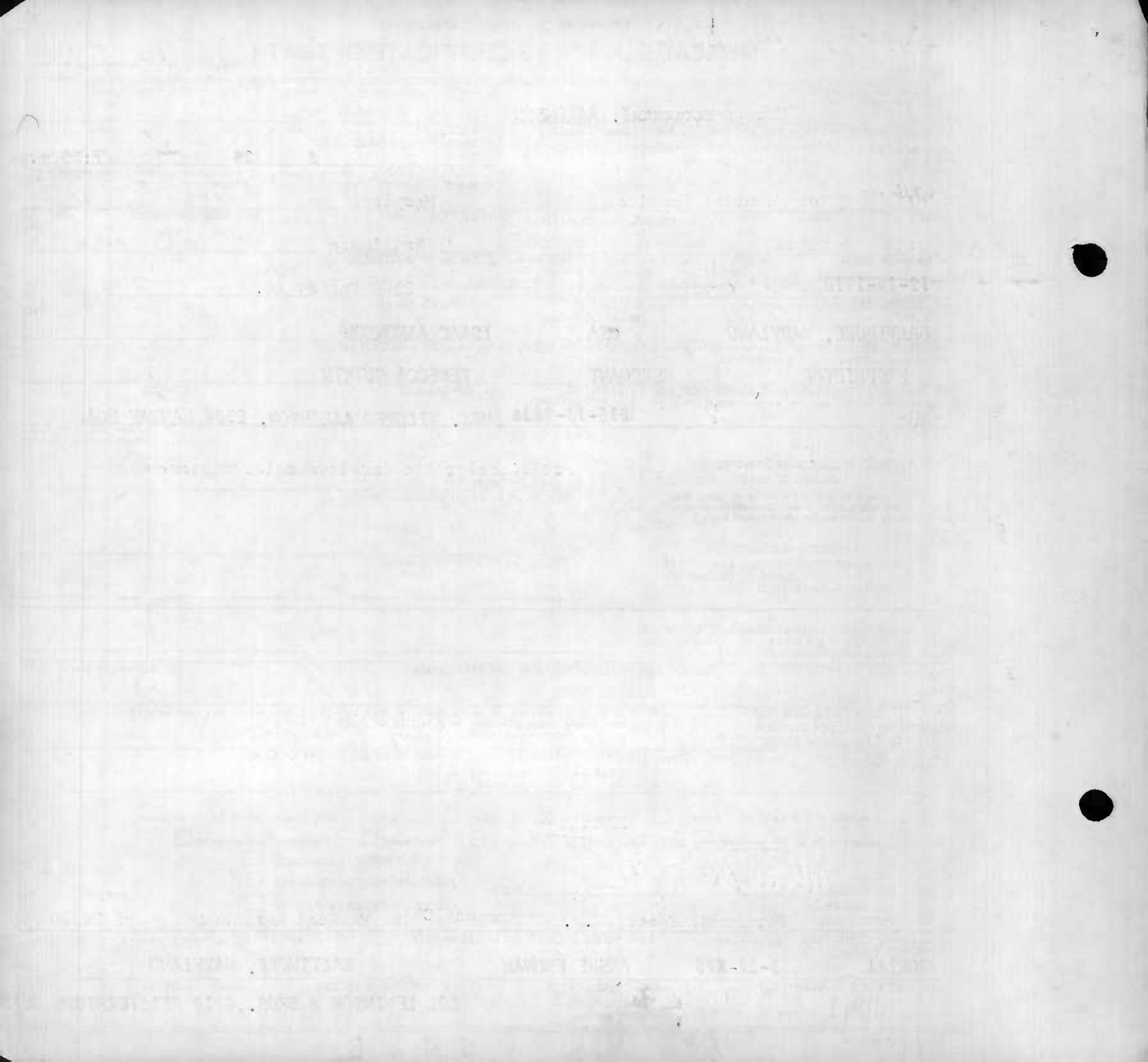
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5502

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Herman Aaronson I. AARONSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 25 70 7:25 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12-14-1910		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC AARONSON		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR	
15. MOTHER'S MAIDEN NAME REBECCA GUTKIN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 215-10-9836		18. INFORMANT ADDRESS MRS. MILDRED AARONSON, 2304 HANWAY ROAD	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) NO	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 5/26/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-27-70	
24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 1.5em;">70 5503</span>	
BIRTH NO. <span style="font-size: 1.5em;">S-526 70 5503</span>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">IDA SINGER</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 25, 1970 6:45 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">HOUSE IN THE PINES, BELVEDERE</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">9925 HOYT CIRCLE</span>	
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10-9-1902</span>
9. AGE (In years last birthday) <span style="font-size: 1.2em;">67</span>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">AT HOME</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">RUSSIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">ISAAC FRIEDMAN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">SARAH ?</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.	
17. INFORMANT <span style="font-size: 1.2em;">MR. MAURICE SINGER, 9925 HOYT CIRCLE, #21133</span>		ADDRESS	
18. <span style="font-size: 1.5em;">174 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span>		CAUSE OF DEATH <span style="font-size: 1.5em;">Necrosis of R foot.</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Metastatic carcinoma</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">C.A. of Breast.</span> (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">4 weeks.</span> <span style="font-size: 1.5em;">6 months.</span> <span style="font-size: 1.5em;">15+ yrs.</span>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">P</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/13</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">5/15</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/15</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. <span style="font-size: 1.2em;">out of town 5/16-5/25/70</span>			
23A. SIGNATURE <span style="font-size: 1.5em;">Alan B. Cohen</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/26/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ALAN B. COHEN</span>		23D. ADDRESS <span style="font-size: 1.2em;">MARYLANDER APTS.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5-27-70</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">HEBREW MT. CARMEL</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 1 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sol E. Levinson</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>		ADDRESS	

2:15 P

KALAMAZOO  
HOSPITAL

WALKER, W. W.  
CHIEF

WALKER, W. W.  
CHIEF

WALKER

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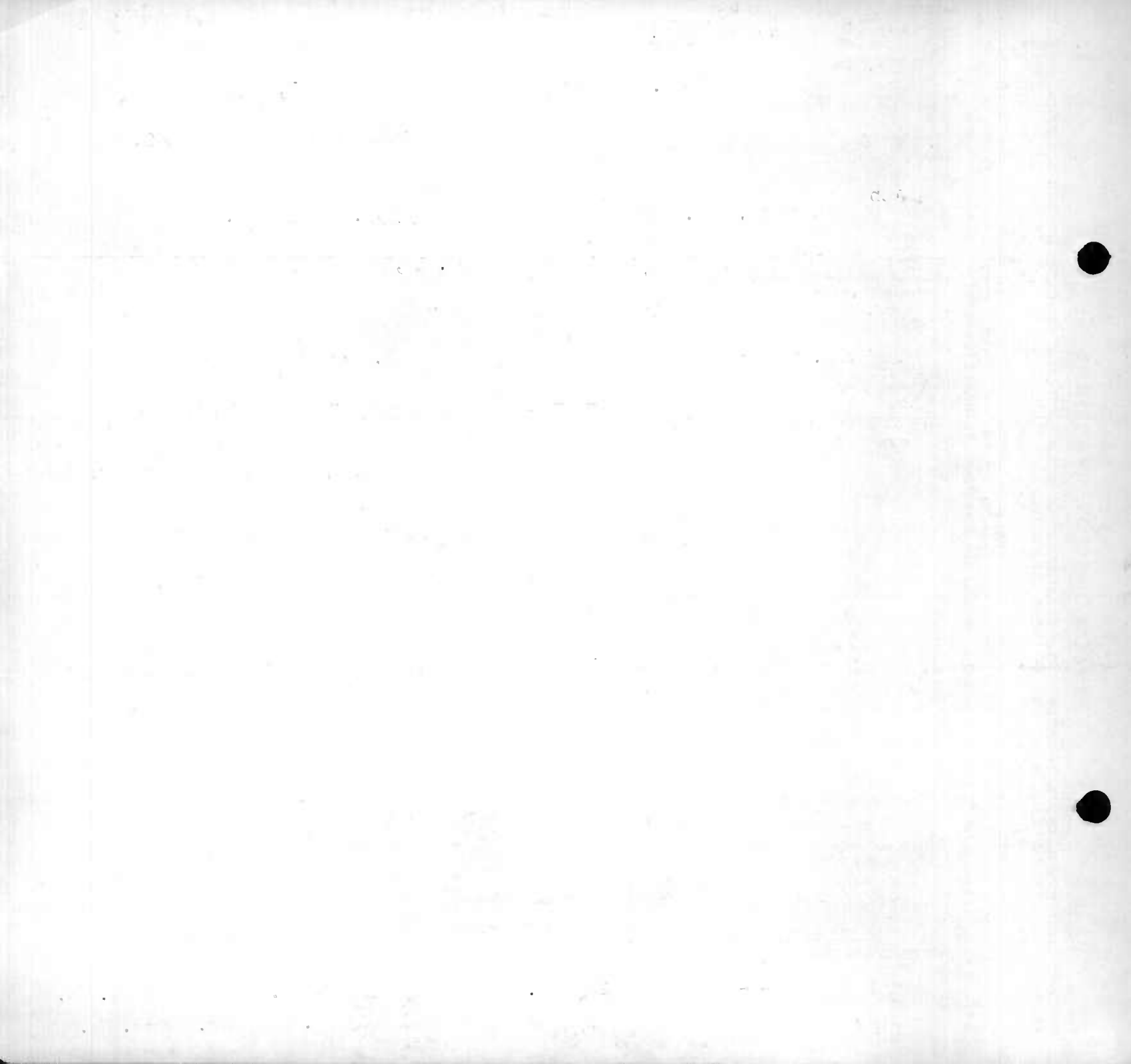
WALKER, W. W.  
CHIEF

WALKER, W. W.  
CHIEF

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5504</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-432</span> <span style="font-size: 1.5em;">70 5504</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John R. Schultz		May 27, 1970 5 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">43</span> South Balto. Gen. Hospital			A. STATE Maryland		
			B. COUNTY 2302		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1343 S. Charles St.					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1915	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator
10B. KIND OF BUSINESS OR INDUSTRY Allied Chemical			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William R. Schultz			14. MOTHER'S MAIDEN NAME Ida M. Sutter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-8732		17. INFORMANT Ruby Schultz - same as # 4	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I 281.01 Coronary Artery Occlusion, instantaneous Pernicious Anemia 5 yrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) None		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 49 to May 27 1970, that (I) (we) last saw the deceased alive on May 27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Garlick				23B. DATE SIGNED May 29, 1970	
23C. PHYSICIAN'S NAME (Type) William L. Garlick, M.D.				23D. ADDRESS 700 N. Charles St., Baltimore, Md. 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-1-70		24C. NAME OF CEMETERY or CREMATORY Lakeview Mem. Park	
24D. LOCATION Balto.		24E. LOCATION (City, town, or county) (State) Carroll Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR E. J. ...		25C. FUNERAL DIRECTOR McGully 130 E. Fort Ave. Balto. Md. 21230	

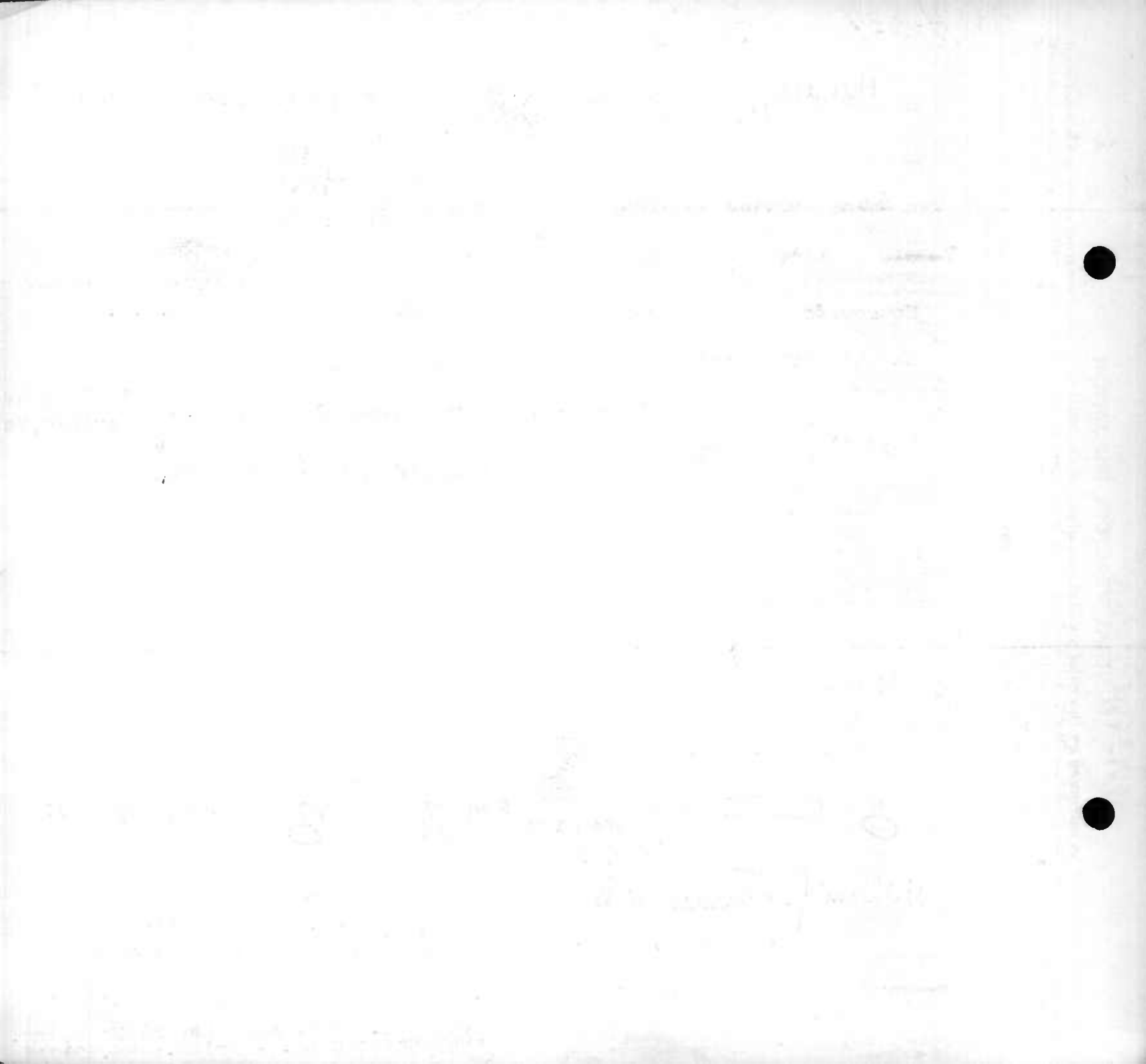


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
70 5505					70 5505				
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>Hundley, Caroline J.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					2. DATE AND HOUR OF DEATH <u>May 27, 1970</u> <u>1:45</u> P.M.				
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>The Johns Hopkins Hospital</u>					4. USUAL RESIDENCE (Where decedent lived, if institution; residence before admission) A. STATE <u>Virginia</u> B. COUNTY <u>V-43</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Martinsville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u>					6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/17/82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		9. AGE (in years last birthday) <u>88</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Charlie Jamison</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
15. Was Decedent Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>231-52-8181</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Simms</u>		
17. INFORMANT <u>825 Starling Av</u>					18. CAUSE OF DEATH <u>173.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cancer of face</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>None</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>—</u>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>May 18</u> 19 <u>70</u> to <u>May 27</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>May 27</u> 19 <u>70</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE <u>William J. Freeman, M.D.</u>					23B. DATE SIGNED <u>5/27/70</u>		23C. PHYSICIAN'S NAME (Type) <u>William J. Freeman, M.D.</u>		
23D. ADDRESS <u>Johns Hopkins Hospital</u> <u>Baltimore, Md. 21201</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>				
24B. DATE <u>5/27/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Martinsville, Va.</u>			24D. LOCATION (City, town, or county) (State) <u>Martinsville, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. ...</u>					25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u> <u>6009 Harford Rd. - Balto., Md. 21214</u>				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-160 70 5506		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5506	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Topper, Guy J</u>		2. DATE AND HOUR OF DEATH <u>27 May 1970 7:05 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt.</u>		C. CITY OR TOWN <u>Balt.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Md. Hospital</u>		E. STREET AND NUMBER <u>1007 W. 37th St.</u>		F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>	6. RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/11</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>PA. PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wm. Guy Topper</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walter</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>186-03-5606</u>		17. INFORMANT <u>Mrs. Elsie M. Topper</u>	
18. <u>136X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Shock</u> (B) <u>Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Atherosclerosis obliterans</u>					
19A. DATE OF OPERATION <u>26 April</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Block to R leg</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1969</u> to <u>27 May 1970</u> that (I) (we) last saw the deceased alive on <u>27 May 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert M. Ollodart</u>		23B. DATE SIGNED <u>27 May 70</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert M. Ollodart</u>	
23D. ADDRESS <u>Univ. of Md. Hosp. Balt.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>Jun 1 1970</u>		25B. NAME OF REGISTRAR <u>Ann Donovan</u>		25C. FUNERAL DIRECTOR <u>Ann Donovan</u>	
25D. ADDRESS <u>3818 Roland Ave.</u>					

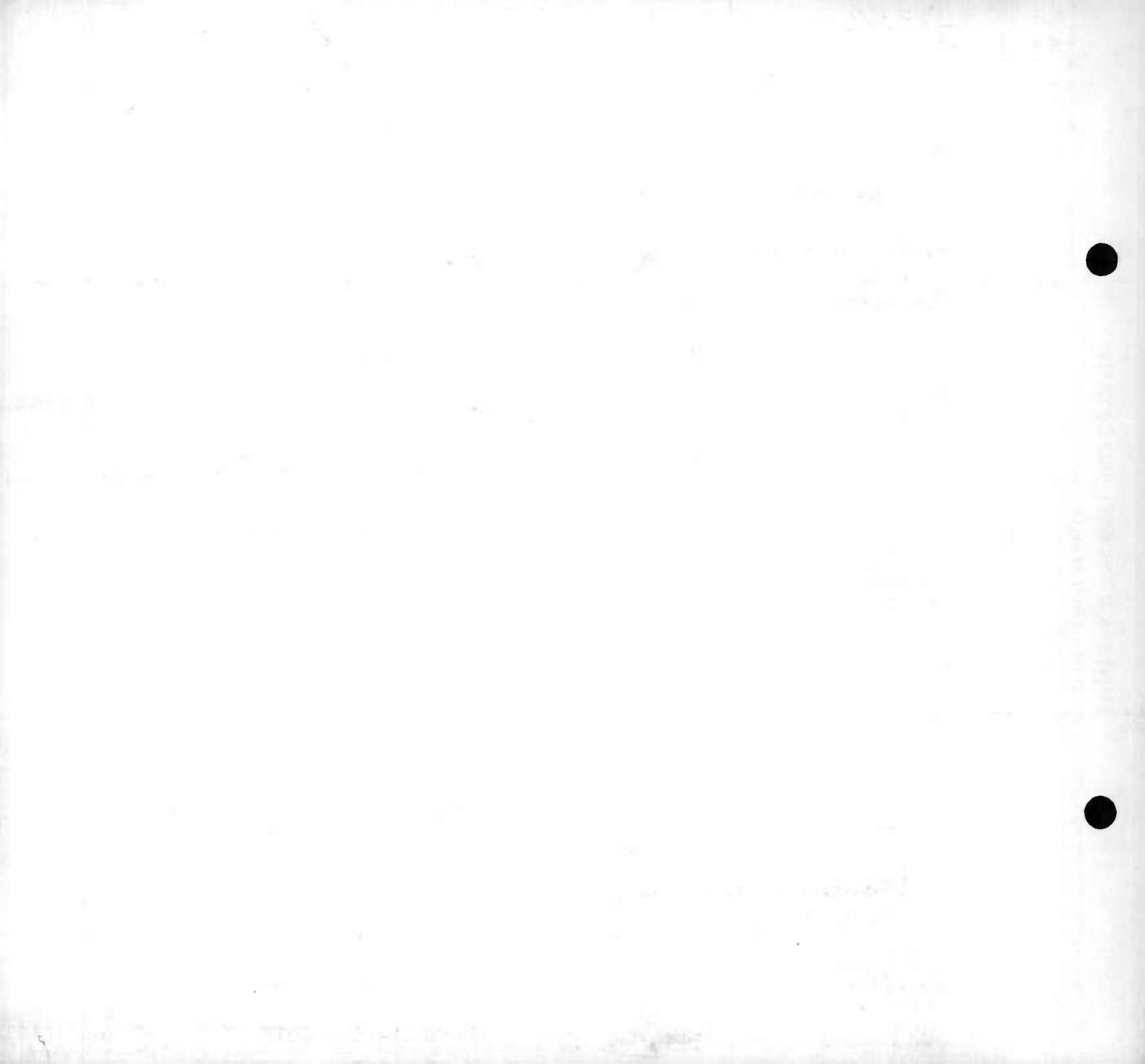
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

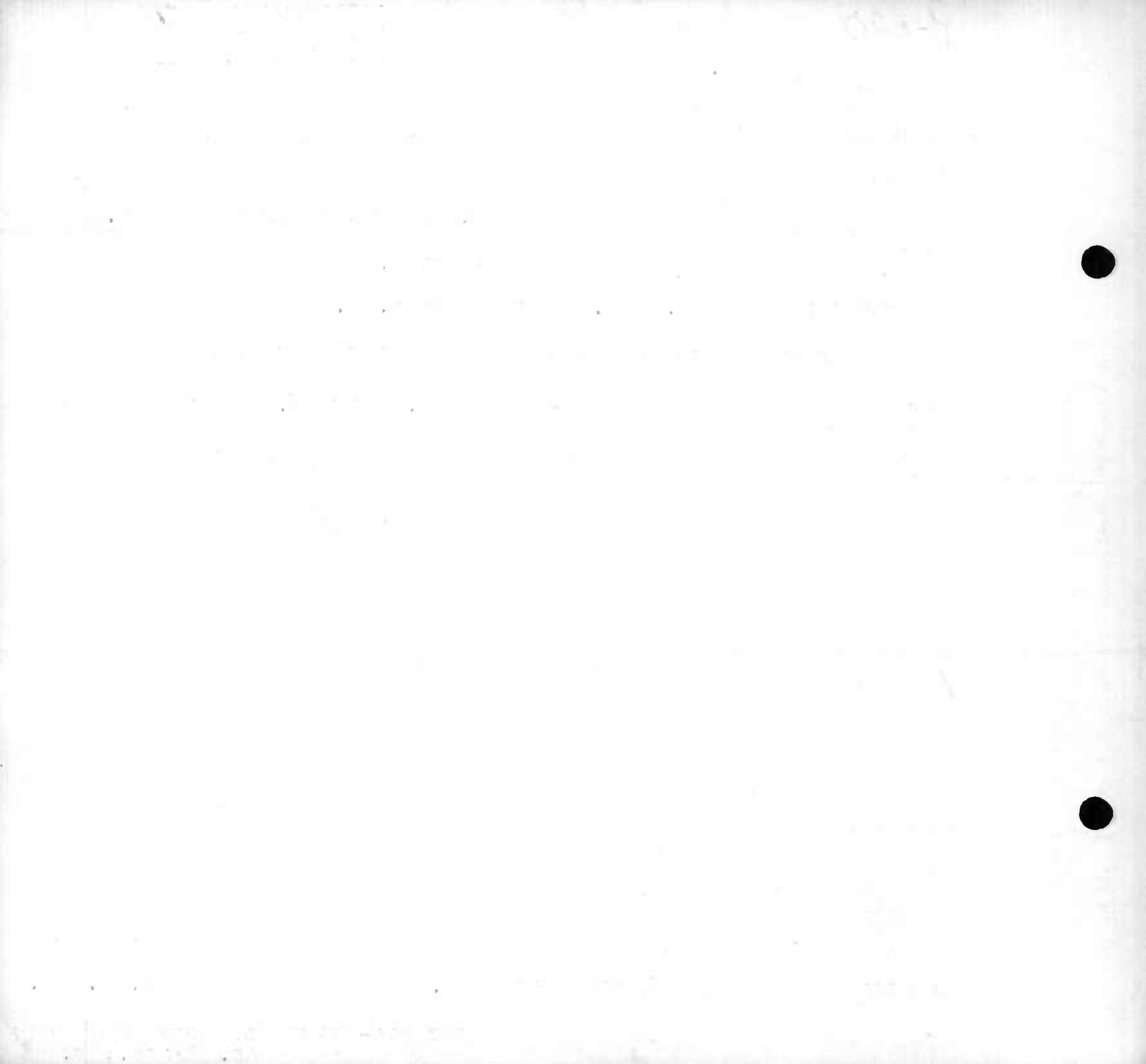
<h2 style="margin: 0;">Baltimore City Health Department</h2> <h1 style="margin: 0;">CERTIFICATE OF DEATH</h1>		REG. NO. <span style="font-size: 2em;">70 5507</span>	
BIRTH NO. <span style="font-size: 2em;">H-322 70 5507</span>		2. DATE AND HOUR OF DEATH May 26, 1970 <span style="float: right;">330 P M.</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Nina Hedges</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">Rhode Island</span> B. COUNTY <span style="font-size: 1.5em;">V-36</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 2em;">90 Long Green Nursing Home</span>		C. CITY OR TOWN <span style="font-size: 1.5em;">Providence</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER	
5. SEX <span style="font-size: 1.5em;">Female</span>	6. RACE <span style="font-size: 1.5em;">Caucasian</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">Oct. 1893</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Homemaker</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">77</span> If Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Iowa</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">James Leonard</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Unknown (W) Renshaw</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">035-38-3397</span>	
17. INFORMANT <span style="font-size: 1.5em;">Mrs William Hedges (Son)</span>		ADDRESS <span style="font-size: 1.5em;">6903 Pinehurst</span>	
18. <span style="font-size: 2em;">431.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cerebral Hemorrhage</span> (B) <span style="font-size: 1.5em;">Cerebral arteriosclerosis</span> (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 2em;">II</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">Instantaneous</span> <span style="font-size: 1.5em;">Several years</span>	
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">4-17</span> 1970 to <span style="font-size: 1.5em;">5-26</span> 1970 that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">5-17</span> 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">Stanley R Steinbach MD</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">5-27-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Dr. Stanley Steinbach</span>		23D. ADDRESS <span style="font-size: 1.5em;">11 Slade Avenue Pikesville, Maryland</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Cremation</span>	24B. DATE <span style="font-size: 1.5em;">5/27/70</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">Greenmount Crematory</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 1 1970</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor MD</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Mitchell Wiedefeld</span>	
		ADDRESS <span style="font-size: 1.5em;">6500 York Road 2121</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BARRIS, JAMES W. 520 DR. COWLEY NO 9-98-93		5508
P-620 70 5508 CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>JAMES W. PARRIS</b>		2. DATE AND HOUR OF DEATH <b>5.26.70 10:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND 38 HOSPITAL.</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MD. NAT. BANK</b>		8. DATE OF BIRTH <b>APRIL 2, 1916</b> 9. AGE (In years last birthday) <b>54</b>
13. FATHER'S NAME <b>JAMES WELLINGTON PARRIS</b>		14. MOTHER'S MAIDEN NAME <b>NAOMI JULIA HALL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-3506</b>		17. INFORMANT <b>MRS. SADIE K. PARRIS</b> ADDRESS <b>SAME</b>
18. <b>394.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MITRAL VALVE DISEASE</b> <b>RHEUMATIC HEART DISEASE</b>		CAUSE OF DEATH <b>CONGESTIVE FAILURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MITRAL VALVE DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>RHEUMATIC HEART DISEASE</b> (C) <b>RHEUMATIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs. 45 min</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>5.26.70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Mitral Stenosis</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>5.22.1970</b> to <b>5.26.1970</b> that (I) (we) last saw the deceased alive on <b>5.26.1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Garvey M.D.</b>		23B. DATE SIGNED <b>5.26.70</b>		23C. PHYSICIAN'S NAME (Type) <b>GARVEY</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>DRUID RIDGE CEM.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jolley</b>		25C. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME</b> ADDRESS <b>6500 YORK RD. BALTO., MD.</b>

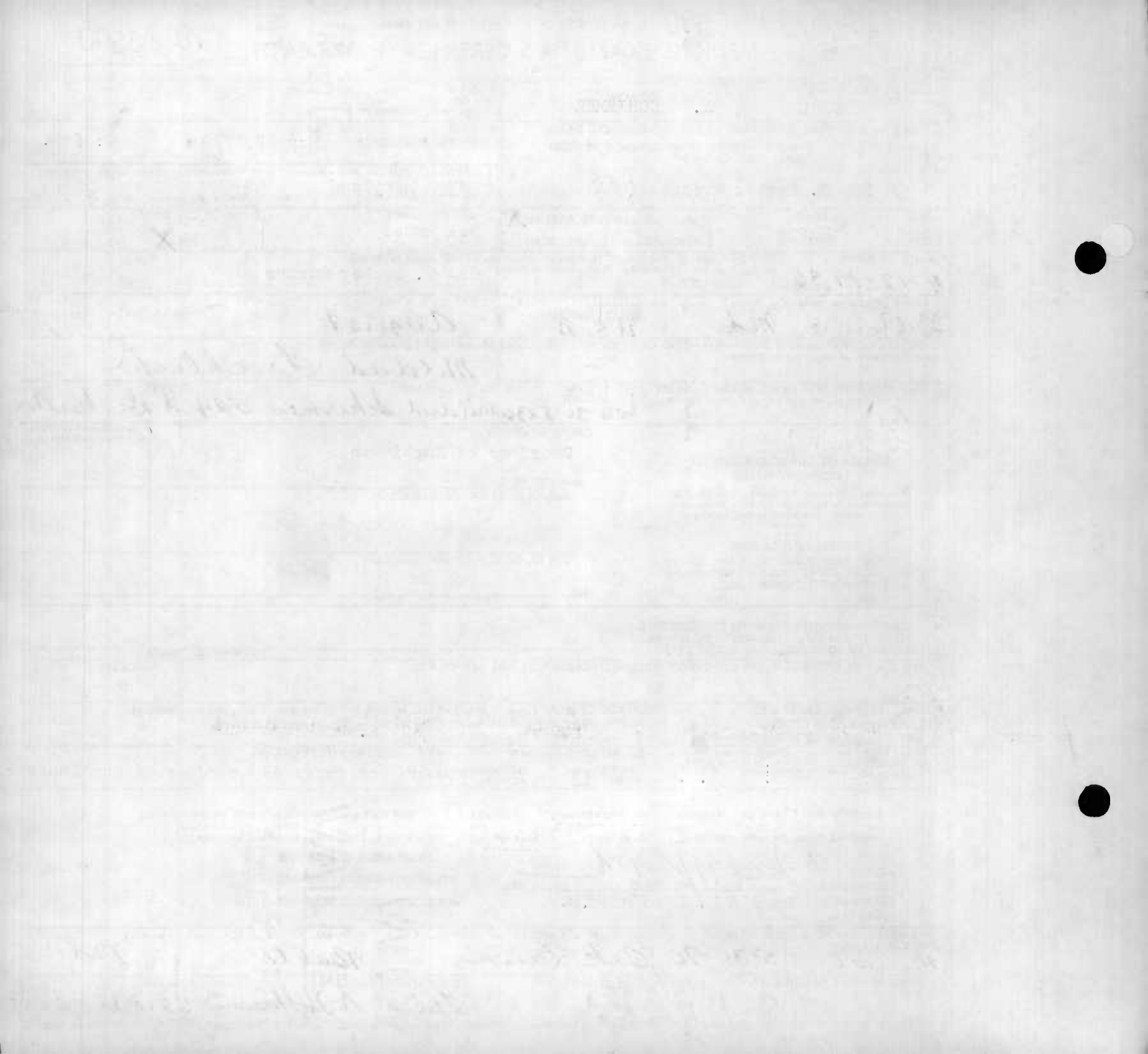




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S-656 70 5509 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 70 5509  
 REG. NO.

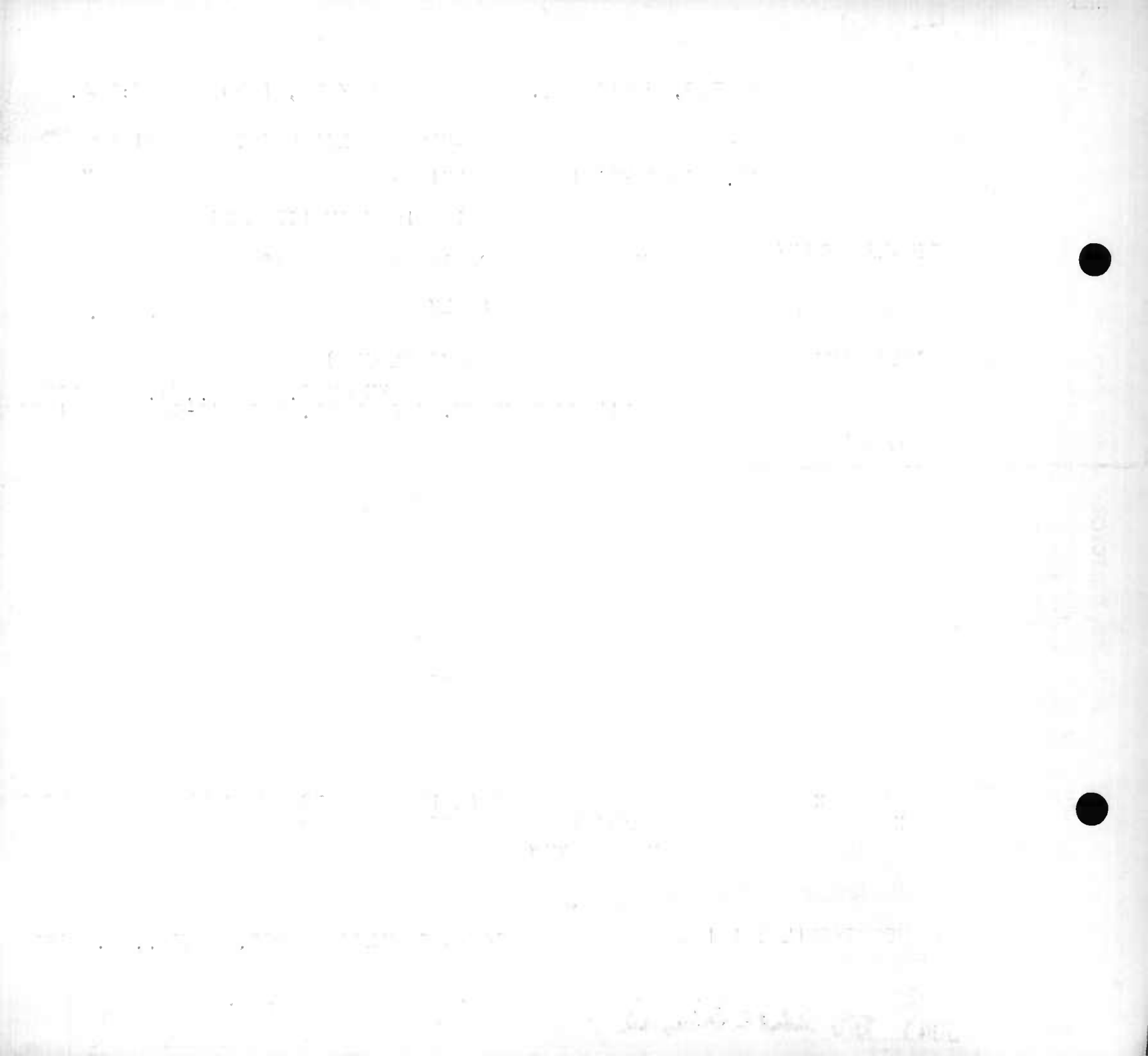
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CARL A. SCHIRMER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 524 S. Decker Avenue (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 27, 1970</b>		Hour <b>9:35 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-17-1936</b>		10. AGE (in years lost birthday) <b>34</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>August</b>		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>102</b>	
15. STREET AND NUMBER <b>524 S. Decker Avenue</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-36-8236</b>	
18. INFORMANT <b>Mildred Schirmer</b>		19. CAUSE OF DEATH <b>Overdose of Barbiturate</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
23A. DATE OF OPERATION <b>0</b>		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) <b>no</b>	
25A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		25C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>524 S. Decker Avenue 102</b>	
26A. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>5-27-70 9:00 A.M.</b>		26B. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26C. HOW DID INJURY OCCUR? <b>Subject ingested overdose of barbiturate</b>	
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
28. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		30. DATE SIGNED <b>5/27/70</b>	
31A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		31B. DATE <b>5-30-70</b>		31C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
31D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		32A. DATE REC'D BY HEALTH DEPT. <b>11/11/70</b>		32B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>	
32C. FUNERAL DIRECTOR <b>Helma A. Hoffmann</b>		32D. ADDRESS <b>3218 Linden St</b>			



# FUNERAL DIRECTOR: IMPORTANT

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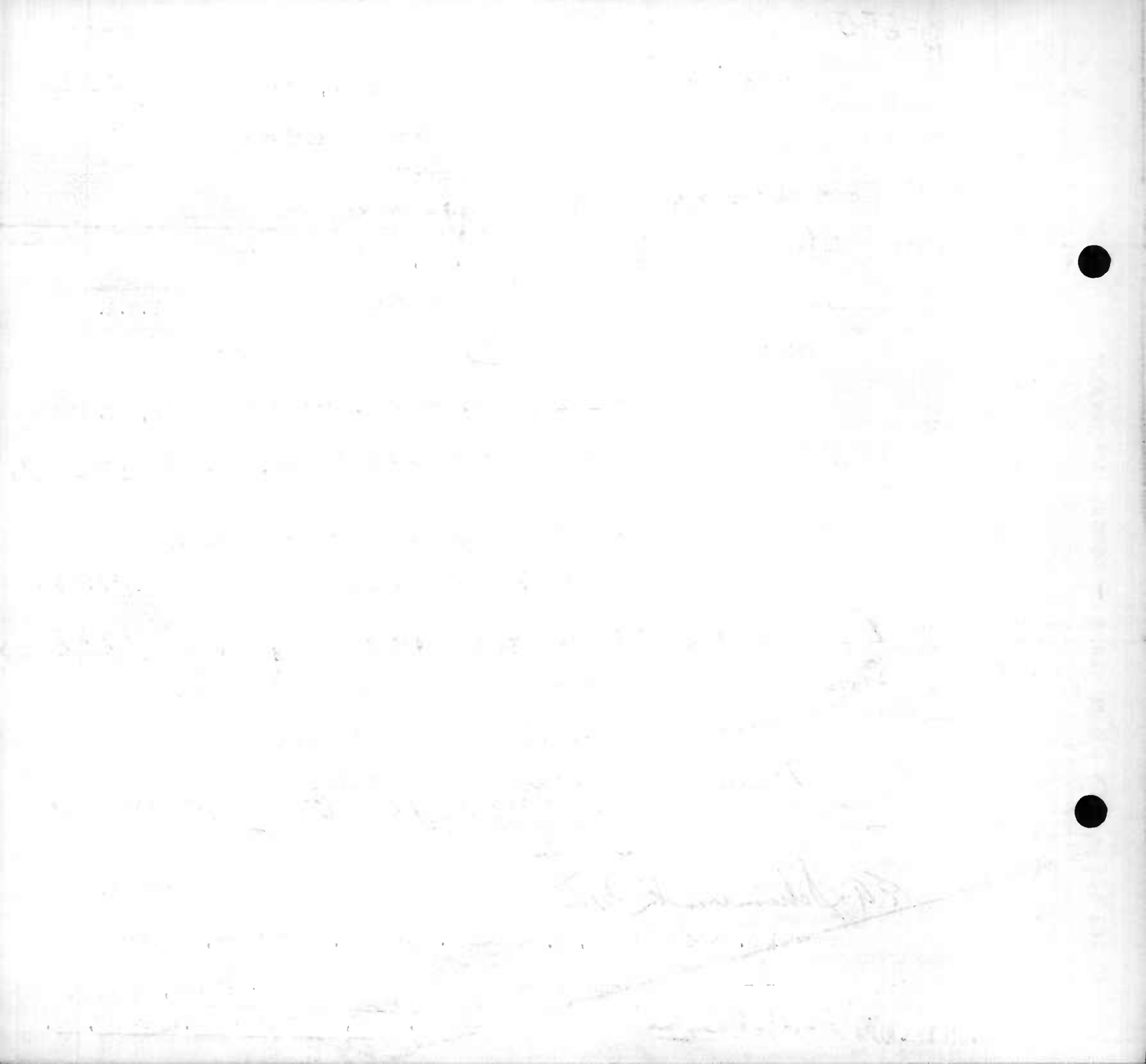
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5510</span>	
BIRTH NO. <span style="font-size: 1.5em;">H-622 70 5510</span>		CERTIFICATE OF DEATH <span style="font-size: 1.5em;">X</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HERZOG, MARIE (J.)</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 27, 1970 5:20A.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">40</span> <span style="font-size: 1.2em;">ST. AGNES HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CO</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">601 MAIDEN CHOICE LANE</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">08 19 89</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">80</span>	10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Cafeteria Supervisor</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ITALY</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">ANGELO PATCH</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY (DELOTTO)</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT <span style="font-size: 1.2em;">X B AVES. BALTO., MD.</span> ADDRESS <span style="font-size: 1.2em;">21229</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214 05 2553</span>			17. ADDRESS <span style="font-size: 1.2em;">ST. AGNES HOSP. RECORDS-CATON &amp; WILKENS</span>		
18. <span style="font-size: 1.5em;">250.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Diabetes Mellitus</span> <span style="font-size: 1.5em;">Myocardial Infarction</span> <span style="font-size: 1.5em;">Pulmonary Edema</span>  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">APRIL 17</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">MAY 27</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 27</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Hermenegildo N. Isidro</span>			23B. DATE SIGNED <span style="font-size: 1.5em;">May 27, 1970</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HERMENEGILDO ISIDRO</span>			23D. ADDRESS <span style="font-size: 1.2em;">CATON &amp; WILKENS AVES. BALTO., MD. 21229</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">June 1, 1970</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Lorraine Park Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 1 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Kelly, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Schwartz</span>			



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BIRTH NO. <u>8-650</u>		70 5511		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5511	
1. NAME OF DECEASED (Type or Print) <u>Mallie Burney</u>				2. DATE AND HOUR OF DEATH <u>May 28, 1970</u> <u>9:30 P. M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Gould Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>2926 Cornwall Road</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 12, 1893</u>		9. AGE (in years last birthday) <u>76</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin Mundy</u>				14. MOTHER'S MAIDEN NAME <u>Alma Davis</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-07-1311B</u>		17. INFORMANT (Son) <u>Mr. Hubert E. Carpenter</u> ADDRESS <u>3209 McShane Way Dundalk, Md. 21222</u>			
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC HYPERTENSIVE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>C.V. DISEASE</u> (C) <u>1967</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-28-70</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>RT. HEMIPLEGIA</u>				<u>1967</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <u>None</u>		21F. HOW DID INJURY OCCUR? <u>None</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>5-10-66</u> to <u>5-28-70</u> that (I) <u>last</u> saw the deceased alive on <u>May 13, 1970</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>E. G. Schimunek</u>				23B. DATE SIGNED <u>5/29/70</u>					
23C. PHYSICIAN'S NAME (Type) <u>Emmanuel A. Schimunek M. D.</u>				23D. ADDRESS <u>842 S. East Ave. Baltimore, Maryland</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-1-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>			

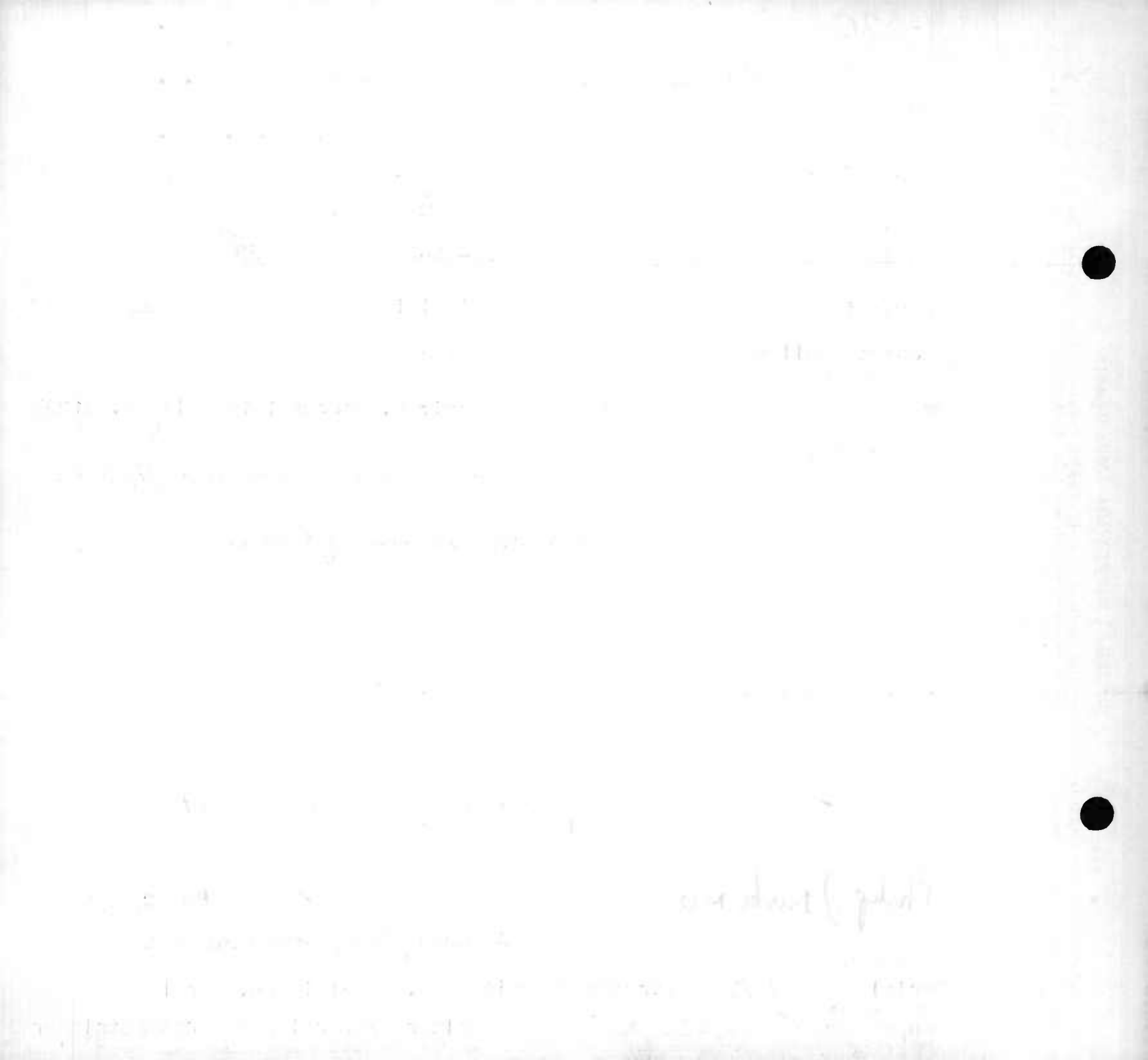


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C-620 70 5512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5512	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) CHURCH, SUSIE E.			2. DATE AND HOUR OF DEATH 5-29-70 8:30 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
BON SECOURS HOSPITAL			1515 COLE ST. BALTO. MD. 1902		
34			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			1515 COLE ST.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	09-02-10	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Virginia		UNITED STATES
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Colley			Laura Eubank		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			220-64-2897		Harris B. Church 1515 Cole St. 21223
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE High intestinal obstruction					
DUE TO, OR AS A CONSEQUENCE OF:					
(B) metastatic carcinoma of pancreas					
DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
72 hours					
9 mos					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from March 19 70 to present 19 70					
that (I) (we) lost saw the deceased alive on May 29 19 70 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Philip J. Burke MD			May 29, 1970		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			2 Stelway Court, Cockeysville, Md		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/2/70		Gardens Of Faith Cem.	
24D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 1 1970		Robert E. Fisher, Jr.		Walters Funeral Home Pratt & Sticker	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 5513		70 5513		70 5513	
1. NAME OF DECEASED (Type or Print) <b>LANDIS, JAMES V.</b>		2. DATE AND HOUR OF DEATH <b>5/26/70 9 30 am M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>W. VIRGINIA</b> B. COUNTY <b>V-45</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b> <b>BALTIMORE, MD. 21201</b>		C. CITY OR TOWN <b>SPRINGFIELD</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/27/54</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>15</b>	
11. BIRTHPLACE (State or foreign country) <b>SPRINGFIELD, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James VIRGIL LANDIS</b>		14. MOTHER'S MAIDEN NAME <b>Nan Reed</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>J. Virgil Landis Springfield W. Va.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumothorax &amp; Pneumonia Complicating TENSION PNEUMOTHORAX</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>BURNS 2° &amp; 3° Burns of 70% of Body PNEUMONIA</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2° &amp; 3° Burns of 70% of Body PNEUMONIA</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>BURNS 2° &amp; 3° 70%</b>		(C) <b>RENAL FAILURE, GRAM NEC. SHOCK</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>RENAL FAILURE, GRAM NEC. SHOCK</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Romney, West Virginia V-45</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>5-2-70 0450</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>House Fire - ? Arson</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>5/2</b> 19 <b>70</b> to <b>5/30</b> 19 <b>70</b> that (I) (we) lost saw the deceased alive on <b>5/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vicente R. Carag Jr. M.D.</b>				23B. DATE SIGNED <b>5/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>VICENTE R. CARAG JR. M.D.</b>				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Romney Hampshire W. Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>William E. Johnson 8521 Loch Raven Bl</b>			

1. The first part of the paper is devoted to a discussion of the

theoretical aspects of the problem.

The second part is devoted to a discussion of the

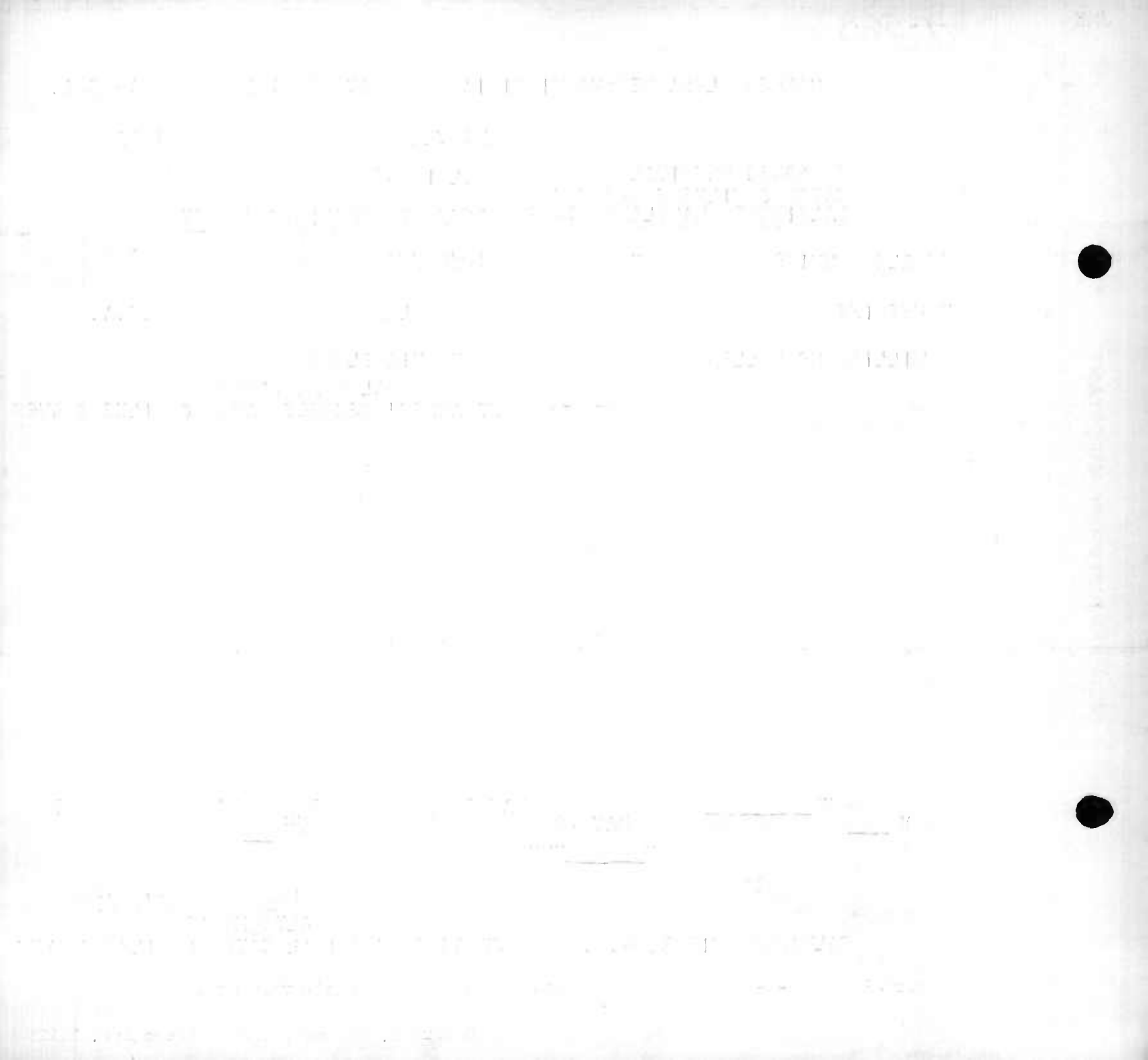
experimental results.

The third part is devoted to a discussion of the

conclusions of the paper.

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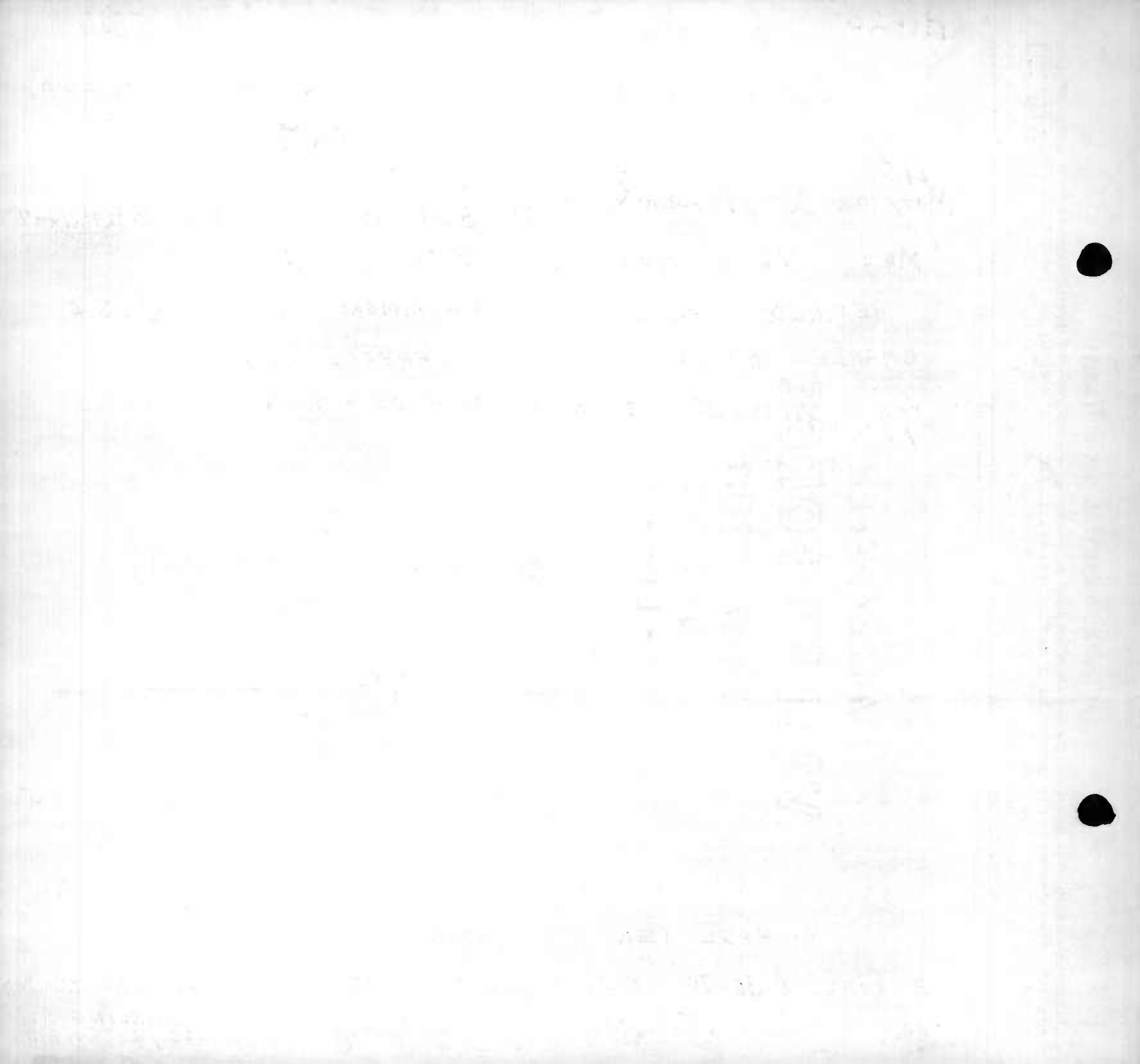
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5514	
BIRTH NO. 4-560		70 5514		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HAMMER, LENA BERTHA VIRGINIA			2. DATE AND HOUR OF DEATH MAY 29, 1970 1:25 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND 21223 2005 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2655 ST BENEDICTS STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/89	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM MC MULLEN			14. MOTHER'S MAIDEN NAME SOPHIA BLUNT		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 219-10-6672		
17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Cardiovascular Disease (B) Diabetes mellitus (C) Right Middle Lobe Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MAY 18 19 70 to MAY 29 19 70 that (X) (we) lost saw the deceased alive on MAY 29 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (g) (not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 05/29/70		
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ, M.D.			23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-1970		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970			
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-623 BIRTH NO. 70 5515		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 5515	
1. NAME OF DECEASED (Type or Print) <b>John Horst</b>			2. DATE AND HOUR OF DEATH <b>5/27/70 11:20 A.M.</b>		
3. PLACE OF DEATH <b>MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2611</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hosp.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>514 S. Bouldin St. #2124</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/30/1889</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GRAND ENT. CO.</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES HORST</b>			14. MOTHER'S MAIDEN NAME <b>BARBARA BREHM</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W. W. I</b>		16. SOCIAL SECURITY NO. <b>215-03-9493</b>	17. INFORMANT <b>MATHILDE A. HORST</b>		ADDRESS <b>SAME</b>
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Lung Carcinoma</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <b>Septic shock</b> <b>pulmonary emboli</b>		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> 19 <b>70</b> to <b>5/27</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Yen</b> M.D.				23B. DATE SIGNED <b>5/27/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL YEN</b>		23D. ADDRESS M.D. <b>MD. GEN. HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5-30-70</b>	24C. NAME of CEMETERY or CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD. BALTO. Co., MD.</b>	
25A. DATE REG'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Charles A. Jailer</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>	

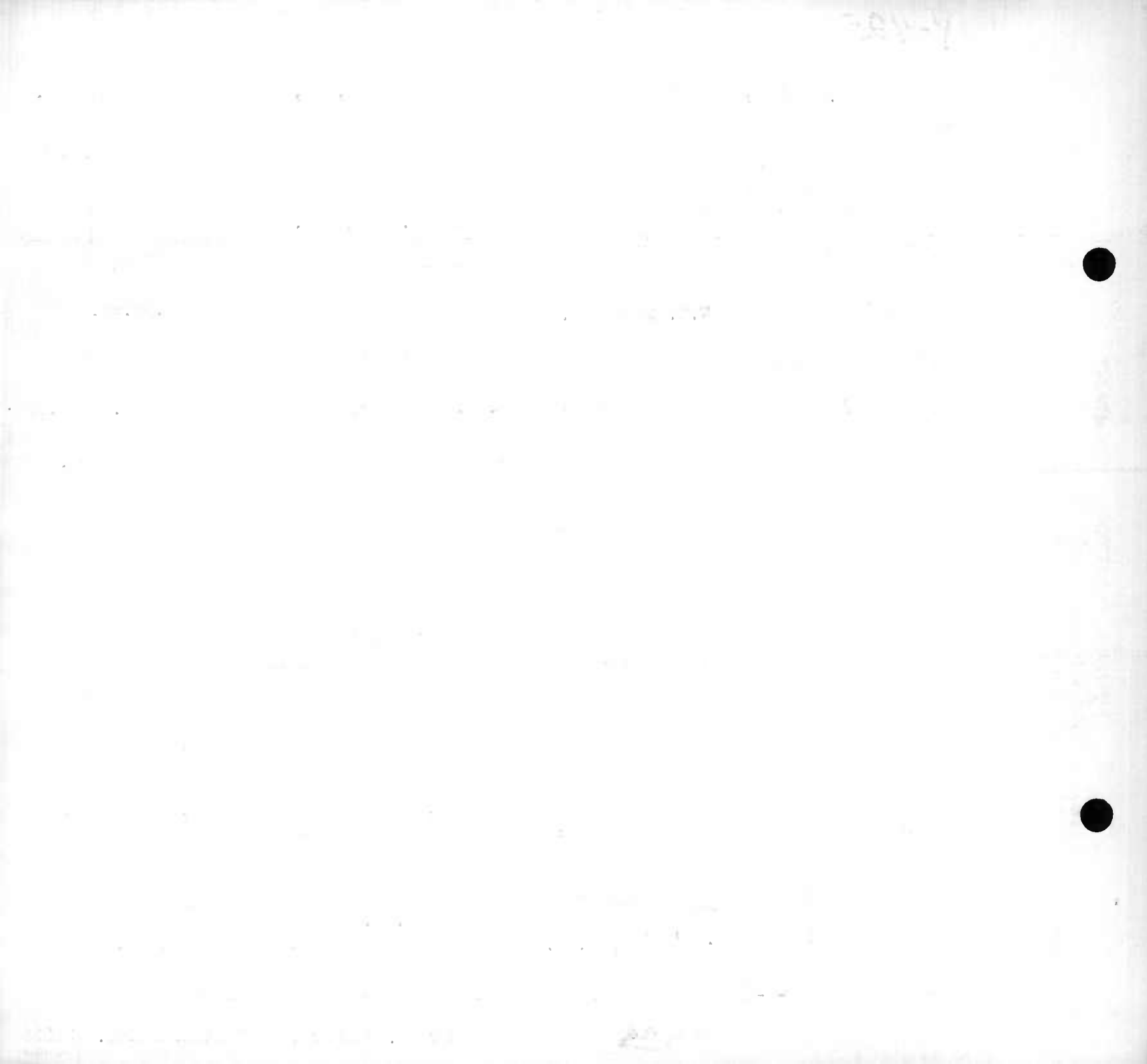




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

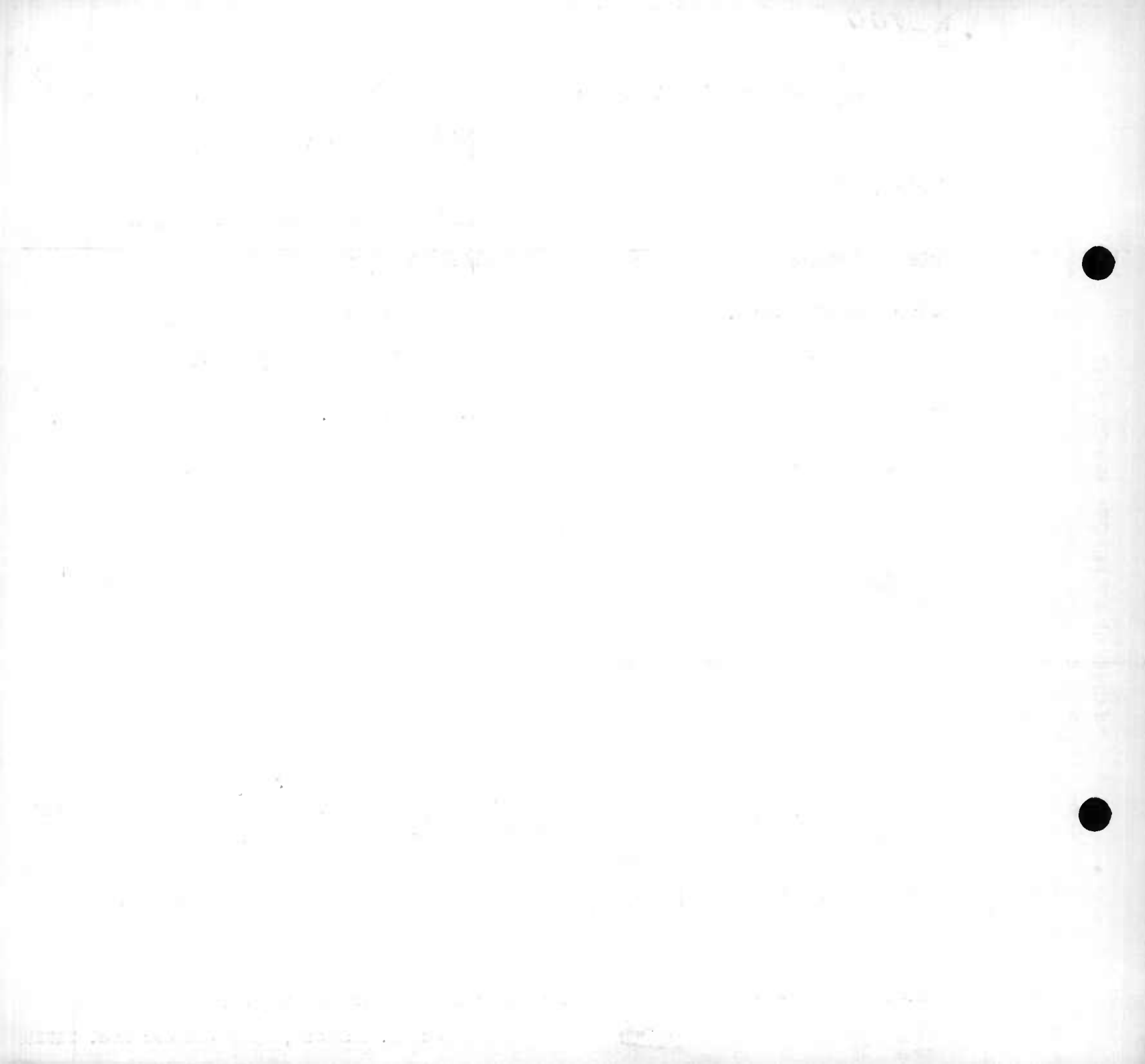
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5516</u>	
P-425 70 5516		BIRTH NO. <u>70 5516</u>			
1. NAME OF DECEASED (Type or Print) <b>PELIKAN, JOSEPH MICHAEL</b>			2. DATE AND HOUR OF DEATH <b>May, 29, 1970 10:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>238 S. Mount St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-14</b>	9. AGE (in years last birthday) <b>55</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>W.T. Cowan Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Michael Pelikan</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Jantz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-30-43 to 4-12-46</b>		16. SOCIAL SECURITY NO. <b>212-01-4413</b>		17. INFORMANT <b>Records</b> ADDRESS <b>V. A. Hospital, 3900 Loch Raven Blvd. Balto., MD.</b>	
18. <b>482.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardiac arrest</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> Nutritional cirrhosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 Hrs.</b> <b>10 Days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>April 6, 1970</b> to <b>May 29, 1970</b> that <b>XX</b> (we) last saw the deceased alive on <b>May 29, 1970</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) (didn't) view the body after death.					
23A. SIGNATURE <b>Richard J. O'Brien, M.D.</b>			23B. DATE SIGNED <b>5/29/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Richard J. O'Brien, M.D.</b>			23D. ADDRESS <b>V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-2-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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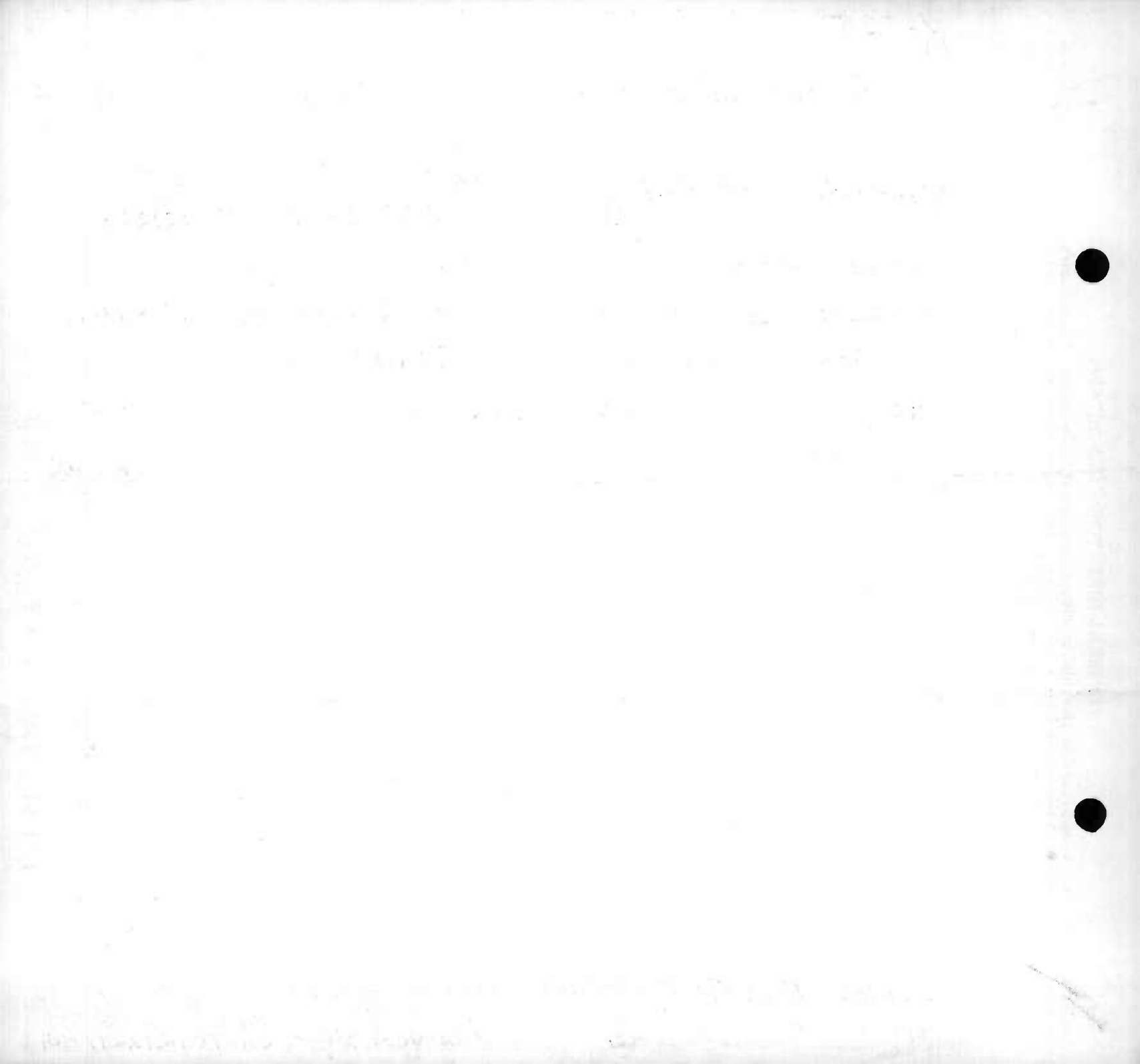
BALTIMORE CITY HEALTH DEPARTMENT									
70 5517					REG. NO. 70 5517				
BIRTH NO. 70 5517					BIRTH NO. 70 5517				
1. NAME OF DECEASED (Type or Print) <b>JOSEPH B. DOVI</b>					2. DATE AND HOUR OF DEATH <b>MAY 29, 1970 6:15 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b> 48					A. STATE <b>MARYLAND</b>				
					C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>921 WOODINGTON RD</b>									
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 18, 1875</b>	9. AGE (in years last birthday) <b>95</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Roofing Cont.</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>JOSEPH DOVI</b>					14. MOTHER'S MAIDEN NAME <b>NATALIE (Unknown)</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>21229</b>			
					Mr. Sebastian J. Dovi, 921 Woodington Rd.				
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ASCUT</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>5-24</b> 19 <b>70</b> to <b>5-29</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>5-29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Gregorio C. Delarosa MD</b>					23B. DATE SIGNED <b>5-29-70</b>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>6-2-1970</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5518</u>	
BIRTH NO. <u>R-525</u>		70 5518		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CATHERINE E. RANKIN</u>			2. DATE AND HOUR OF DEATH <u>5/27/70</u> <u>9:40 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>NORTH CHARLES HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2608</u>		
5. SEX <u>FEMALE</u>			6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		8. DATE OF BIRTH <u>11-26-06</u>
13. FATHER'S NAME <u>JOHN P. CONNELLY</u>			14. MOTHER'S MAIDEN NAME <u>ANNA E. WOLF</u>		9. AGE (In years last birthday) <u>63</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>212-056212</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>
17. INFORMANT <u>JOHN L. RANKIN</u>			ADDRESS <u>SAME</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>182.0 I</u> <u>TERMINAL METASTATIC CA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CA OF ENDOMETRIUM</u>			(B) <u>10 YRS</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>5/16</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> 19 <u>70</u> to <u>5/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>NO A Cabiling MD</u>				23B. DATE SIGNED <u>5/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>NO A CABILING MD</u>				23D. ADDRESS <u>NORTH CHARLES HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-30-70</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. STANISLAUS CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>6515 BOSTON AVE., BALTO., MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>			
25B. NAME OF REGISTRAR <u>Charles E. Jiles</u>		25C. FUNERAL DIRECTOR <u>Charles E. Jiles</u>			
25D. ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
W-210		70 5519		70 5519			
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Wisby, Elizabeth</u>				5/27/70 7:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>GRANADA Nursing Home Inc.</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>5600</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4200 Liberty Heights Ave.</u>				C. CITY OR TOWN <u>Westminster</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>Rt 6, Box 116</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/9/94</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Royal</u>				14. MOTHER'S MAIDEN NAME <u>Liza Carroll</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219 36 1832</u>		17. INFORMANT <u>Mr. Joseph Wisby</u> ADDRESS <u>Westminster, Md.</u>	
18. <u>250.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <u>Diabetes Mellitus</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>5/27/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS CONTRIBUTING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Work At <input type="checkbox"/> While At <input type="checkbox"/> Work At <input type="checkbox"/> Work					
22. I certify that (I) (this hospital) attended the deceased from <u>5/26/70</u> 19 to <u>5/27/70</u> 19 that (I) (we) last saw the deceased alive on <u>5/27/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Hollis Seunarine</u>				23B. DATE SIGNED <u>5/27/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE</u>				23D. ADDRESS <u>1801 Granberry Rd</u>		(State) <u>BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-30-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Evergreen Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Finksburg Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Harry W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	

Mr. [unclear]  
[unclear]  
[unclear]

[unclear]  
[unclear]

~~Mr. [unclear]~~  
[unclear]

[unclear]  
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[unclear]  
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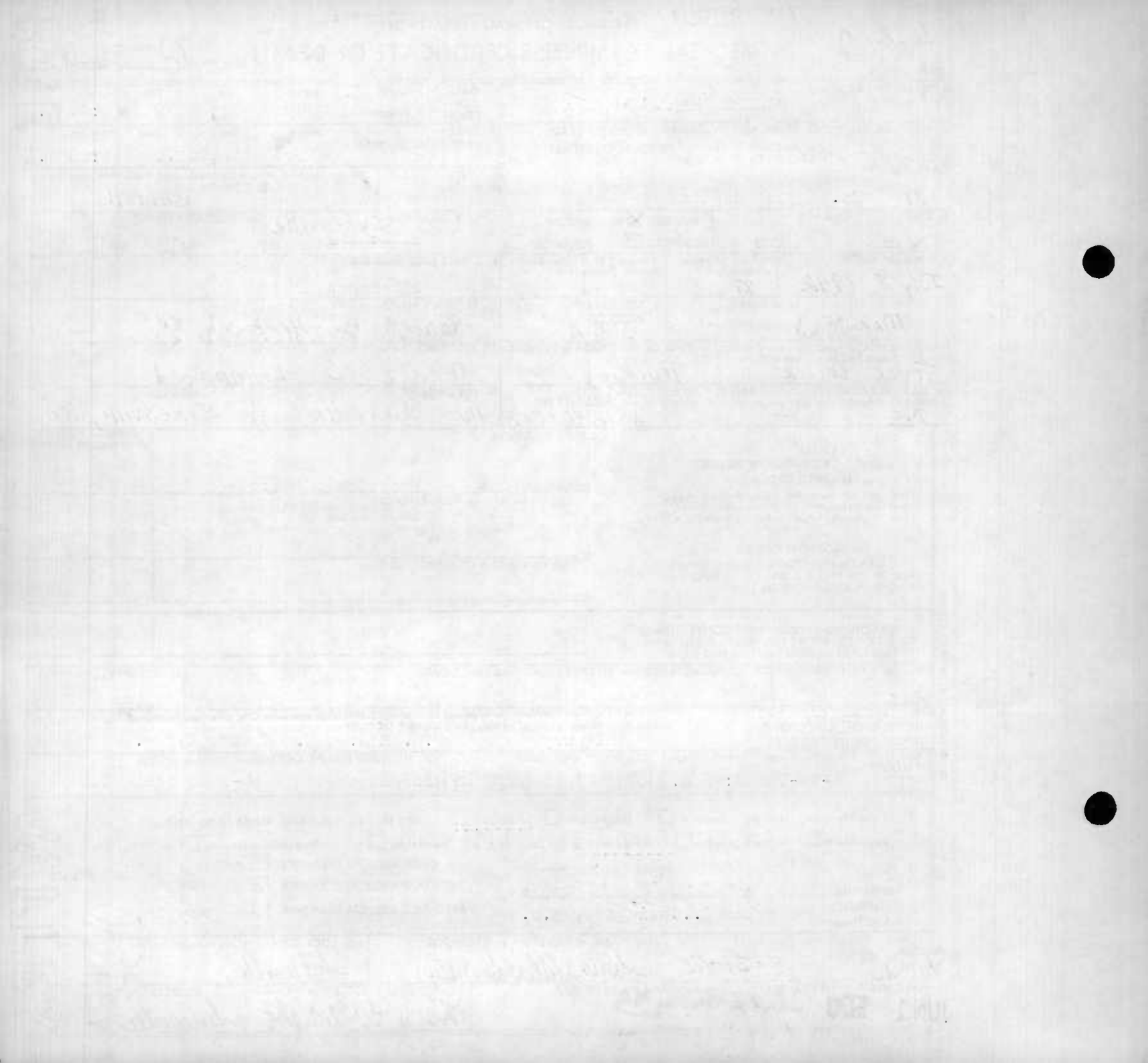


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

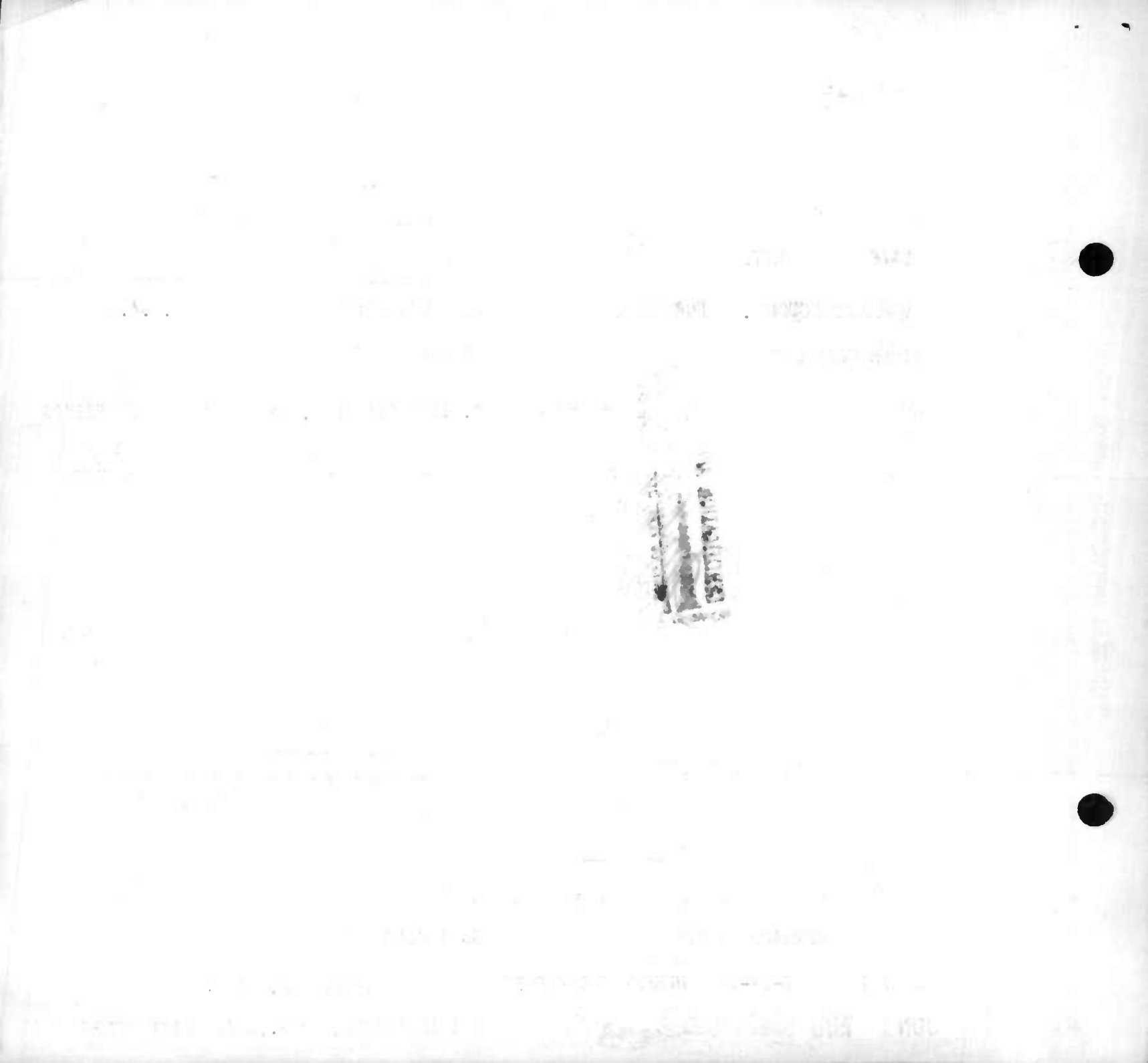
1. NAME OF DECEASED (Type or Print) ROBERT C. HARBAUGH, JR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 28, 1970 Hour 5:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year May 28, 1970 Hour 5:20 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Sykesville Baltimore	
9. DATE OF BIRTH July 8, 1942		10. AGE (In years last birthday) 27	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Trucking	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212 40 8317	
18. INFORMANT Mrs. Shirley Harbaugh		ADDRESS Sykesville, Md.	
19. CAUSE OF DEATH E812.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		21. AUTOPSY? (Yes or No) Yes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22D. TIME OF INJURY (APPROX.) 5-28-70 3:45 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) U.S. Rte. #1 N. of Laurel, Md.		22F. HOW DID INJURY OCCUR? Passenger in truck-auto collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 28, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-70	
24C. NAME OF CEMETERY or CREMATORY Springfield Cemetery		24D. LOCATION (City, town, or county) (State) Sykesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-216 70 5521				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5521	
1. NAME OF DECEASED (Type or Print) <u>Weissberg, Charles</u>				2. DATE AND HOUR OF DEATH <u>5/28/70</u> <u>3 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Emergency Room</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2755</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5805 Pimlico Road</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-88</u>		9. AGE (in years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXXXXXMFG.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON WEISBERG</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-9176</u>		17. INFORMANT ADDRESS <u>MRS. LEON GOLDBERG, 723 HOWARD ROAD #21208</u>			
18. <u>E 887 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Fractured skull</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if one or more gave rise to the above cause (A) UNDERLYING CONDITION lost. <u>Cerebral ischemia and Generalized A.S.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Fractured skull</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cerebral ischemia and Generalized A.S.</u>						<u>10 yrs.</u>	
19A. DATE OF OPERATION <u>5/28/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fractured skull</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>5805 Pimlico Rd. 2755</u>			
21D. TIME OF INJURY (APPROX.) <u>5 28 70 12:30</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell and fractured skull</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>5/28/70</u> to <u>present</u> and that (I) (we) lost saw the deceased alive on <u>5/28/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Bernard Burgin M.D.</u>				23B. DATE SIGNED <u>5/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>BERNARD BURGIN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-29-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

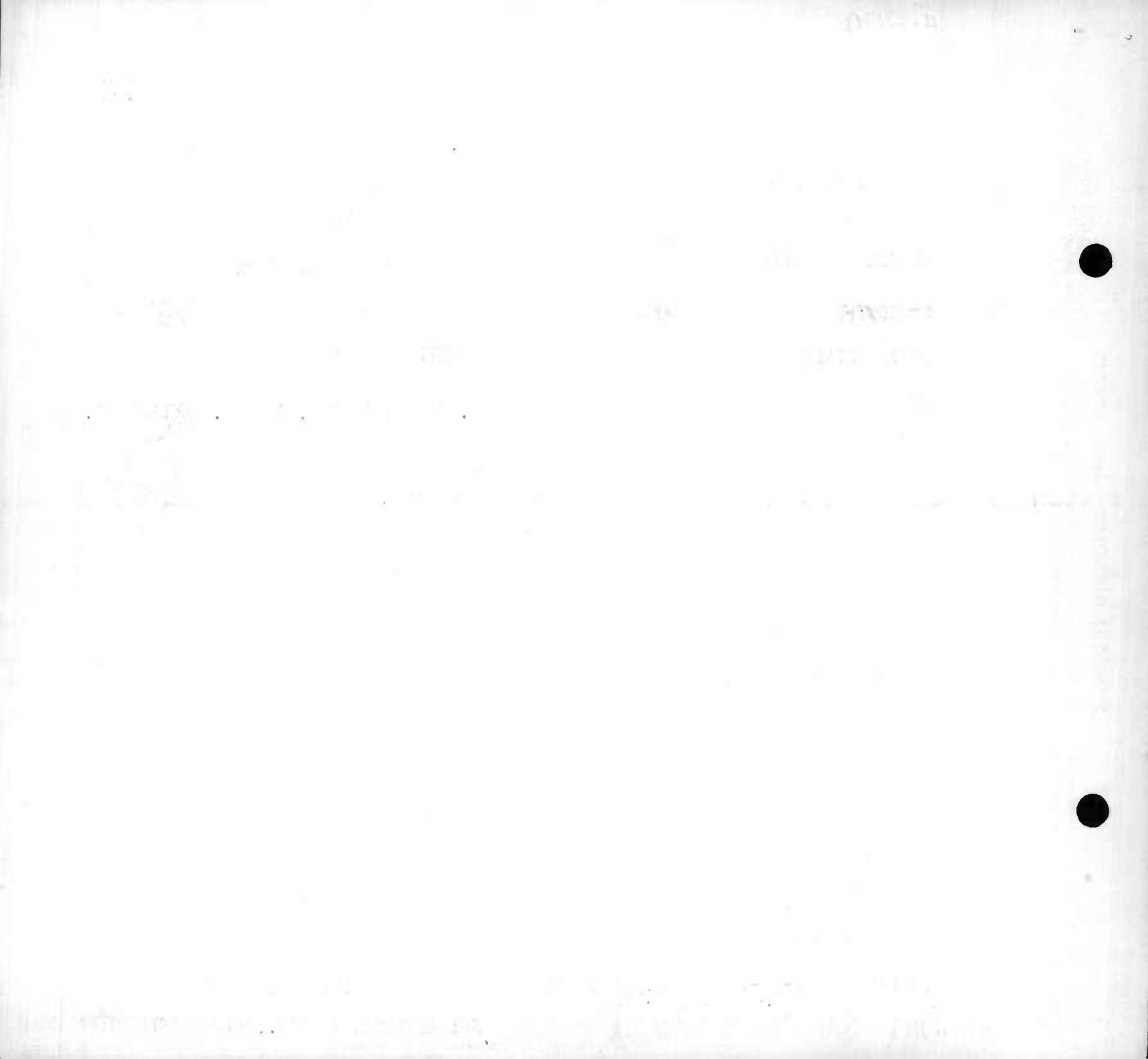
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5522</u>	
BIRTH NO. <u>K-450 70 5522</u>		1. NAME OF DECEASED (Type or Print) <u>William KLINE</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. BALTO.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		2. DATE AND HOUR OF DEATH <u>5/28/70 10:25 A.M.</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-10-1888</u>		9. AGE (in years last birthday) <u>81</u>		10. AGE (in years last birthday) <u>81</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>SAMUEL KLAIVANSKY</u>		14. MOTHER'S MAIDEN NAME <u>IDA LONG</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-01-9823</u>		17. INFORMANT <u>MR. MANNY M. KLINE, 3416 GARRISON FARMS RD. #8</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412.3 I</u> <u>Ante Pulmonary edema 8 days</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anteriosclerotic Heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular accident</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION <u>5/19/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/19/70</u> to <u>5/28/70</u> and that (I) (we) last saw the deceased alive on <u>5/28/70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. MC VENY</u>				23B. DATE SIGNED <u>5/28/70</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>A. MC VENY</u>		<u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>BURIAL</u>		<u>5-29-70</u>		<u>MIKRO KODESH BETH ISRAEL</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
<u>BALTIMORE, MARYLAND</u>		<u>JUN 1 1970</u>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>Robert E. Bailey</u>		<u>SOL LEVINSON &amp; BROS.</u>		<u>6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5523</u>	
7-200		70 5523		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SOPHIE FOX</u>		2. DATE AND HOUR OF DEATH <u>5/27/70 - 16:25 A</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u> B. COUNTY <u>2755</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2026 W. Rogers Ave. #68</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12/25/94</u>	9. AGE (in years lost birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>DAVID WEINER</u>		14. MOTHER'S MAIDEN NAME <u>YETTA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. ALBERT ERDMAN, 2026 W. ROGERS AVE. #9</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>massive myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>following pace-maker implantation (heart block)</u> (C) <u>generalized atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>generalized atherosclerosis</u>					
19A. DATE OF OPERATION <u>35/26/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>HEART BLOCK</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/23/70</u> 19 <u>70</u> to <u>5/27/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/26/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>5/27/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JOAO C. ARAUJO M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-29-70</u>		24C. NAME of CEMETERY or CREMATORY <u>WORKMEN CIRCLE</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			

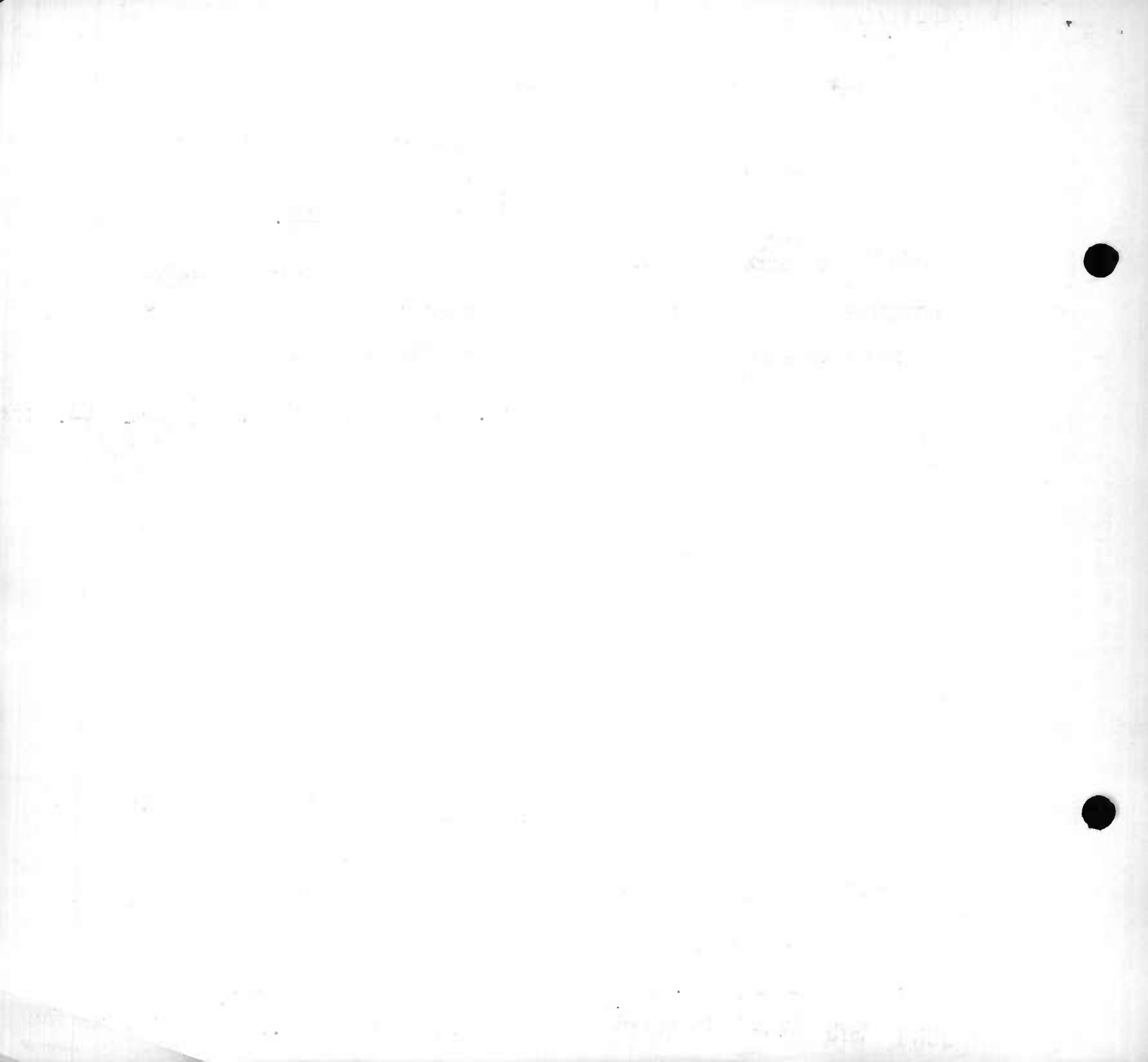




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

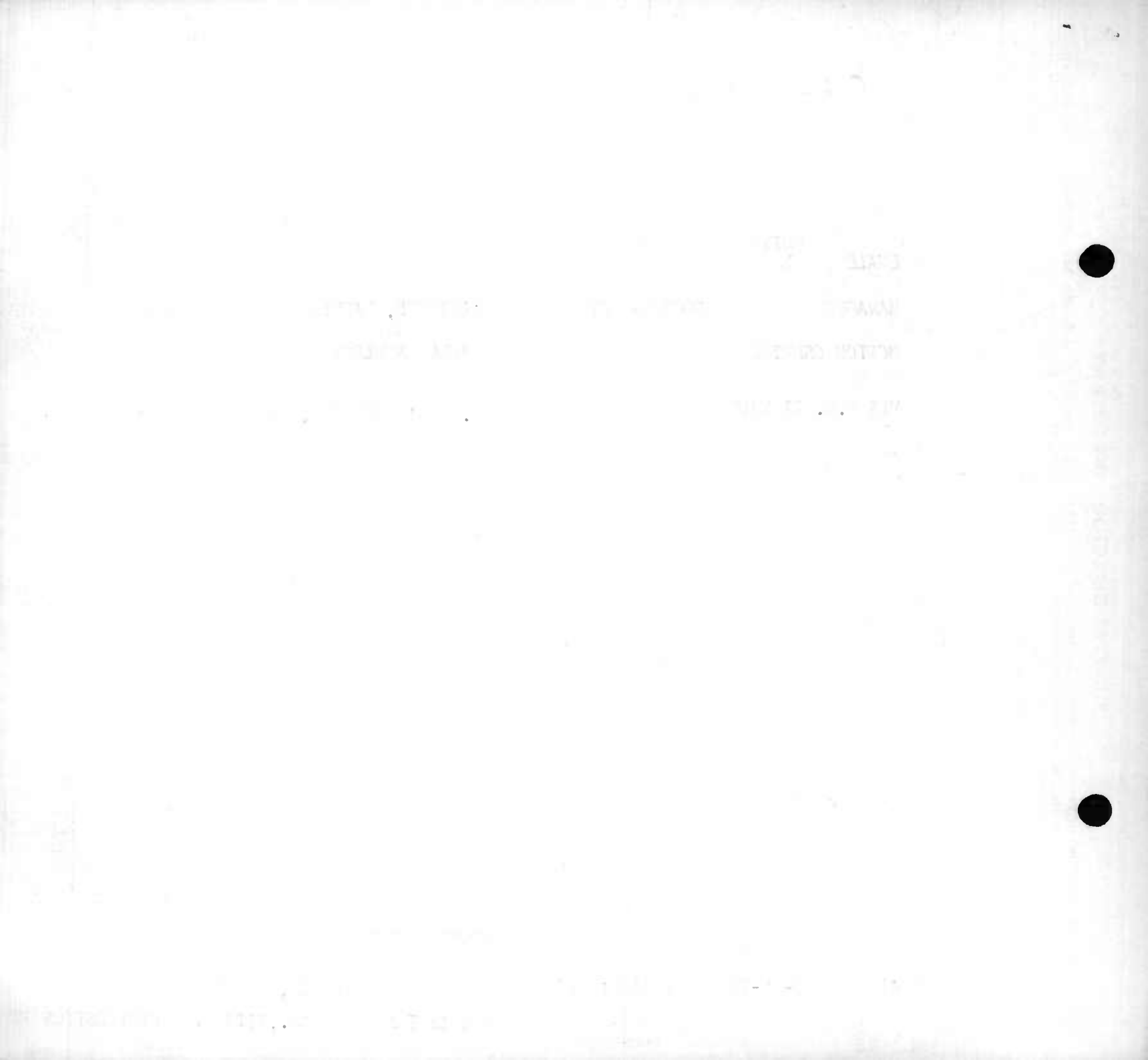
BALTIMORE CITY HEALTH DEPARTMENT				70 5524		70 5524	
G-314				70 5524		70 5524	
BIRTH NO. <u>2</u>				1. NAME OF DECEASED (Type or Print) <u>Gottfeld, Charlotte</u>		2. DATE AND HOUR OF DEATH <u>5/27/70</u> <u>12<sup>10</sup></u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hosp.</u>				A. STATE <u>MARYLAND</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 601 N. Broadway</u>				C. CITY OR TOWN <u>Balt. Md</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>6500 McCLEAN BLVD.</u>		<u>2747</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-03</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>			11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>XXXXXXXXX UNKNOWN</u>				
14. MOTHER'S MAIDEN NAME <u>XXXXXXXXX UNKNOWN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>MR. GUNTHER MAX GOTTFELD, ARLINGTON, MASS. 02174</u>				
18. <u>157.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>metastatic cancer</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>cancer of head of pancreas</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>metastatic cancer</u> (B) <u>cancer of head of pancreas</u> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks +</u> <u>3 weeks +</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>1/4/30/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>head of pancreas</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1970</u> to <u>May 27, 1970</u> that (I) (we) last saw the deceased alive on <u>May 27, 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David G. Ansel</u>				23B. DATE SIGNED <u>5/27/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>David G. Ansel, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-29-70</u>		24C. NAME of CEMETERY or CREMATORY <u>CHEVRA AHAVAS CHESSED</u>		24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



# FUNERAL DIRECTOR: IMPORTANT

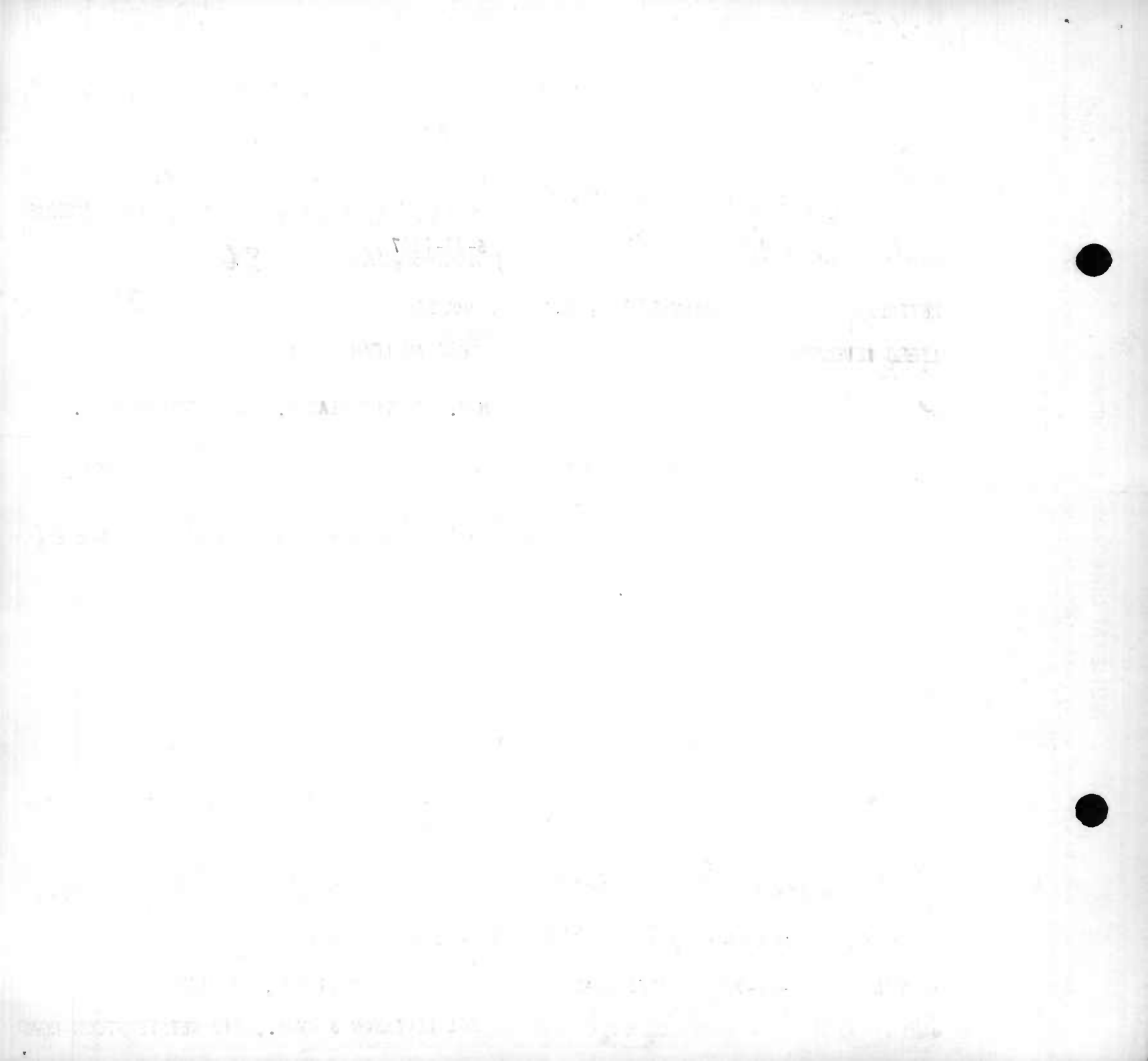
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5525</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 1.5em;">0-265-70 5525</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ELLIOFT LEE OSHRINE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/28/70 10 A. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">42 SINAI HOSP. - BALTO</span>			A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">2740</span>		
C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO</span>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <span style="font-size: 1.2em;">3314 LUDGATE RD</span>					
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/8/23</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">46</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MANAGER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">FOOD MARKET</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">MORTON OSHRINE</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ANNE SMULSON</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES W.W. II NAVY</span>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. DORIS OSHRINE, 3314 LUDGATE ROAD #21215</span>			
18. <span style="font-size: 1.2em;">153.3 I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Hepatic coma</span>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Cirrhosis</span>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Probable metastatic disease</span>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Tumor Sigmoid colon</span>					
(C) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">II</span>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (naffly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/19/70</span> 19 to <span style="font-size: 1.2em;">5/28/70</span> 19 that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/28/70</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">A. M. Viny</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/28/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DEGREE</span>				23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5-29-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">SHAAREI ZION</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">ROSEDALE, MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 1 1970</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 8100 6010 REISTERSTOWN RD</span>			



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VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
F-230 70 5527		70 5527			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
LESLIE FEKETE		MAY 27, 1970		10:12 A.M.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION		8. STREET AND NUMBER		9. DATE OF BIRTH	
SINAI HOSPITAL		5507 STUART AVENUE		OCT. 5, 1901	
10. SEX		11. RACE		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14. KIND OF BUSINESS OR INDUSTRY		15. BIRTHPLACE (State or foreign country)	
BARBER		CITIZENS BARBER SHOP		HUNGARY	
16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18. CITIZEN OF WHAT COUNTRY?	
? SCHWARTZ		SZERENA LOWY		U.S.A.	
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		20. SOCIAL SECURITY NO.		21. INFORMANT	
NO				MR. THOMAS FEKETE, 6626 VINCENT LANE, APT. 301	
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		23. CAUSE OF DEATH		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 day	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		1 x months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atrial Fibrillation			
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/20 1965 to 5/27 1970, that (I) (we) last saw the deceased alive on 5/25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]		5/27/70		DR. ISRAEL ZINBERG	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		5-29-70		OHEB SHALOM MEMORIAL PARK	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 1 1970		[Signature]		SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
26A. LOCATION (City, town, or county)		26B. ADDRESS		26C. STATE	
REISTERSTOWN, MARYLAND		[Address]		[State]	

UNITED STATES

OF DISTRICTS

OF THE DISTRICT OF COLUMBIA

AND THE DISTRICT OF MARYLAND

WHITE

MALE

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IN THE DISTRICT OF COLUMBIA

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IN THE DISTRICT OF COLUMBIA

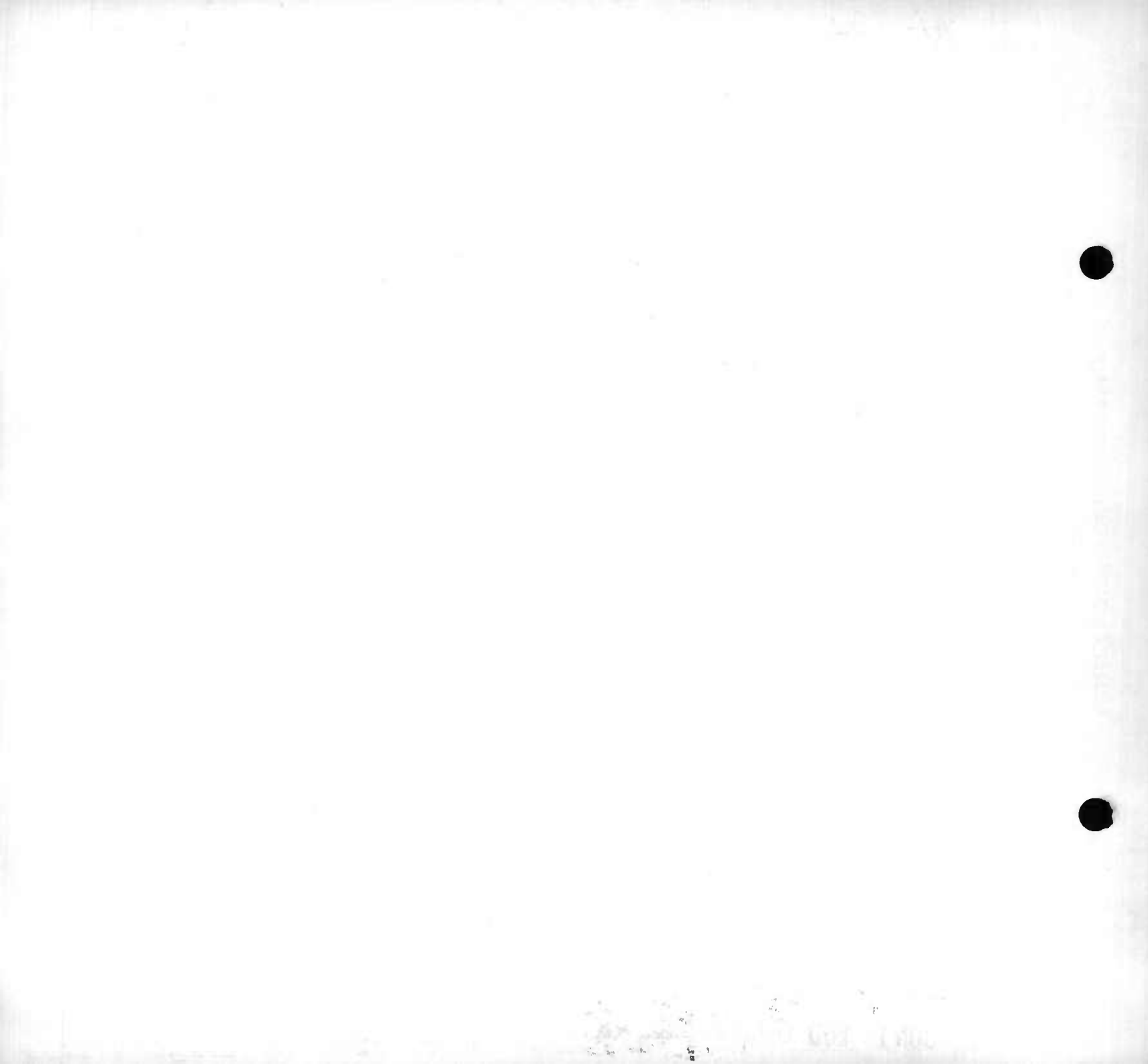
IN THE DISTRICT OF COLUMBIA



# FUNERAL DIRECTOR: IMPORTANT

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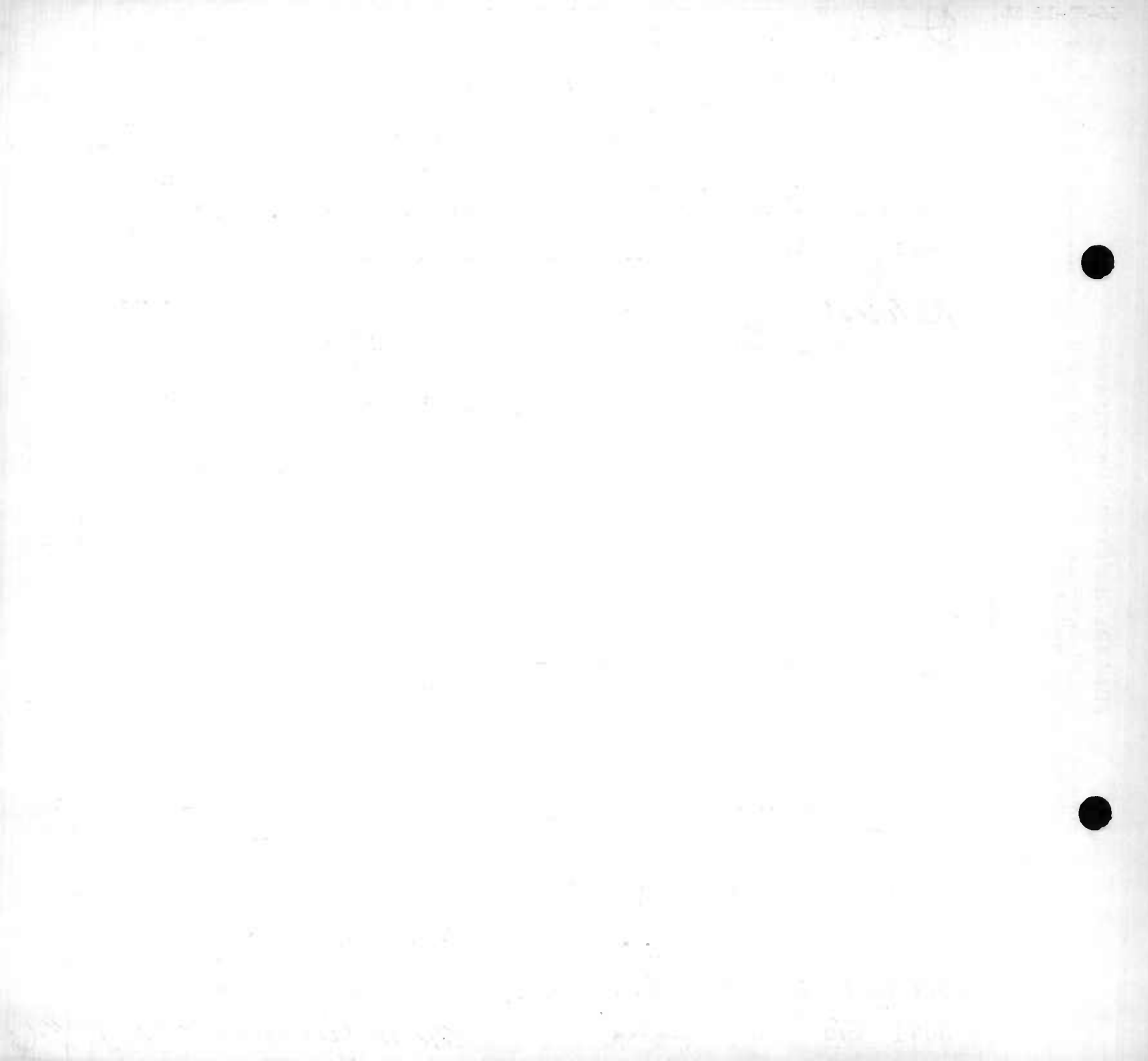
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>70 5528</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>NEWMAN, George H.</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>5-28-70 1 6 A. M.</u>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <u>MARYLAND</u> <b>B. COUNTY</b> <u>ANN ARUNDEL</u> <b>C. CITY OR TOWN</b> <u>Glen Burnie</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>106 King George Drive</u>			
<b>5. SEX</b> <u>male</u>		<b>6. RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-17-97</u> <b>9. AGE</b> (In years last birthday) <u>72</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Shoemaker</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pa</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Thomas Newman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>? ALpha TowFER</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW2</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Family</u>		<b>ADDRESS</b> <u>same</u>	
<b>18. CAUSE OF DEATH</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <u>Intracerebral Haemorrhage</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <u>Hypertension</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b> _____							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>							
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>May 27</u> <u>1970</u> <b>to</b> <u>May 28</u> <u>1970</u> <b>that (I) (we) last saw the deceased alive on</b> <u>May 28</u> <u>1970</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>[Signature]</u>				<b>23B. DATE SIGNED</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Schnitzer</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>5-31-70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>BLACK OAK CEMETERY</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>POT MATILDA, Pa.</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 1 1970</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Faber, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>JOHN H. HAHN</u>		<b>ADDRESS</b> <u>4200 Pennington Ave.</u>	



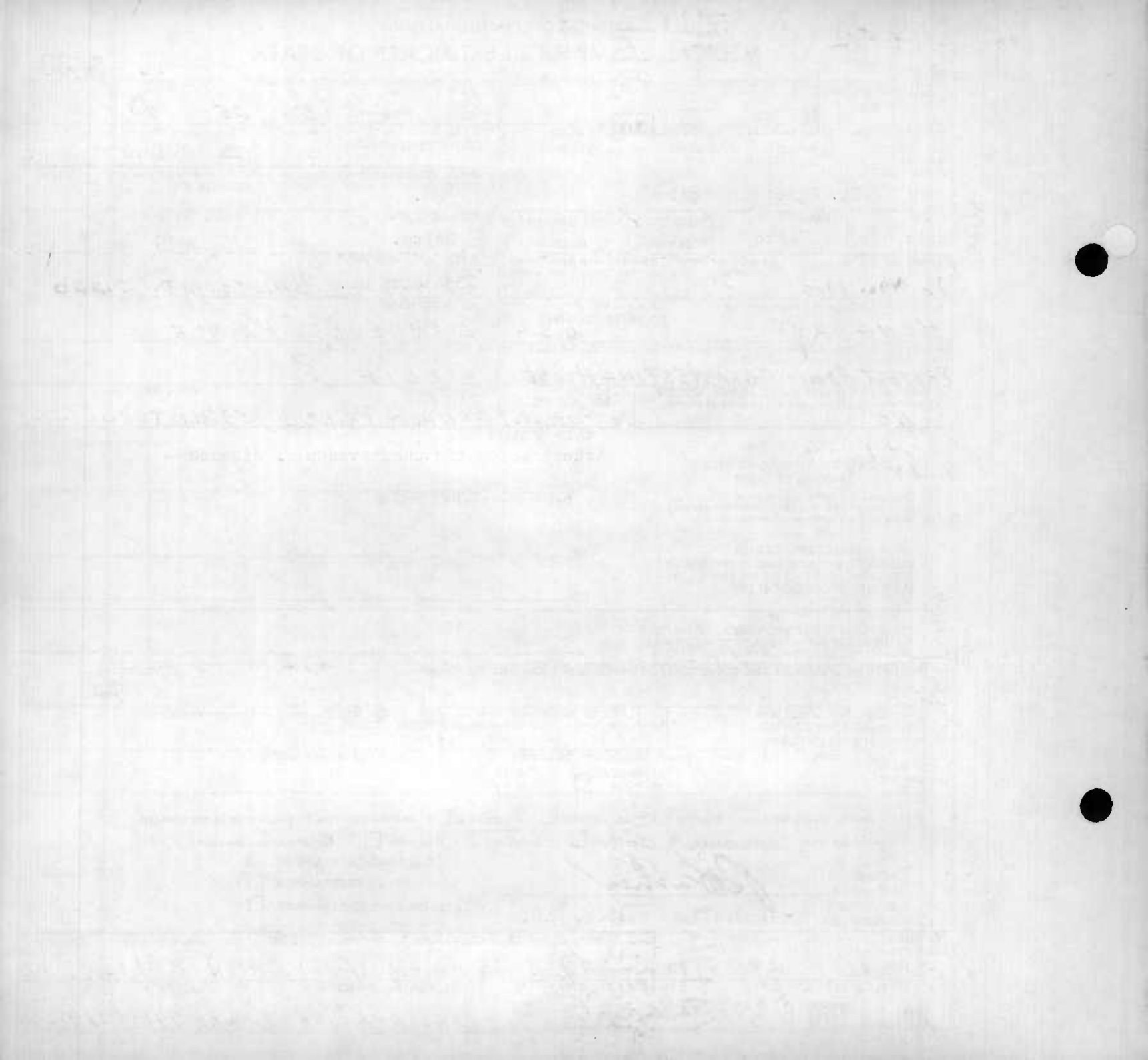
## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

G-225 70 5529		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5529	
BIRTH NO.		1. NAME OF DECEASED Type or Print		2. DATE AND HOUR OF DEATH	
		Geoghegan, Marie H		5/26/70 11 35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Maryland Balto.		5300	
Baltimore City Hospital 4940 EASTERN AVENUE #21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7258 Bridgewood Dr. #21224			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-85	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Maryland	
13. FATHER'S NAME August Tuckerman		14. MOTHER'S MAIDEN NAME Marie Mc Cuska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-0358-D		17. INFORMANT Records: BCH 4940 Eastern Avenue	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio resp arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(B) Acute MI DUE TO, OR AS A CONSEQUENCE OF:		~ 9 hrs	
		(C) ASCVD		Yrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26-19 70 to 5-26-19 70 that (I) (we) last saw the deceased alive on 5-26-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ronald G. Haller M.D.		23B. DATE SIGNED 5/26/70	
23C. PHYSICIAN'S NAME (Type) Ronald G. Haller M.D.		23D. ADDRESS BCH 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 5/29/70	24C. NAME OF CEMETERY OR CREMATORY Oakwood	24D. LOCATION (City, town, or county) (State) Balto Md		
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Charles E. Mann	ADDRESS 6067 Harford Rd		



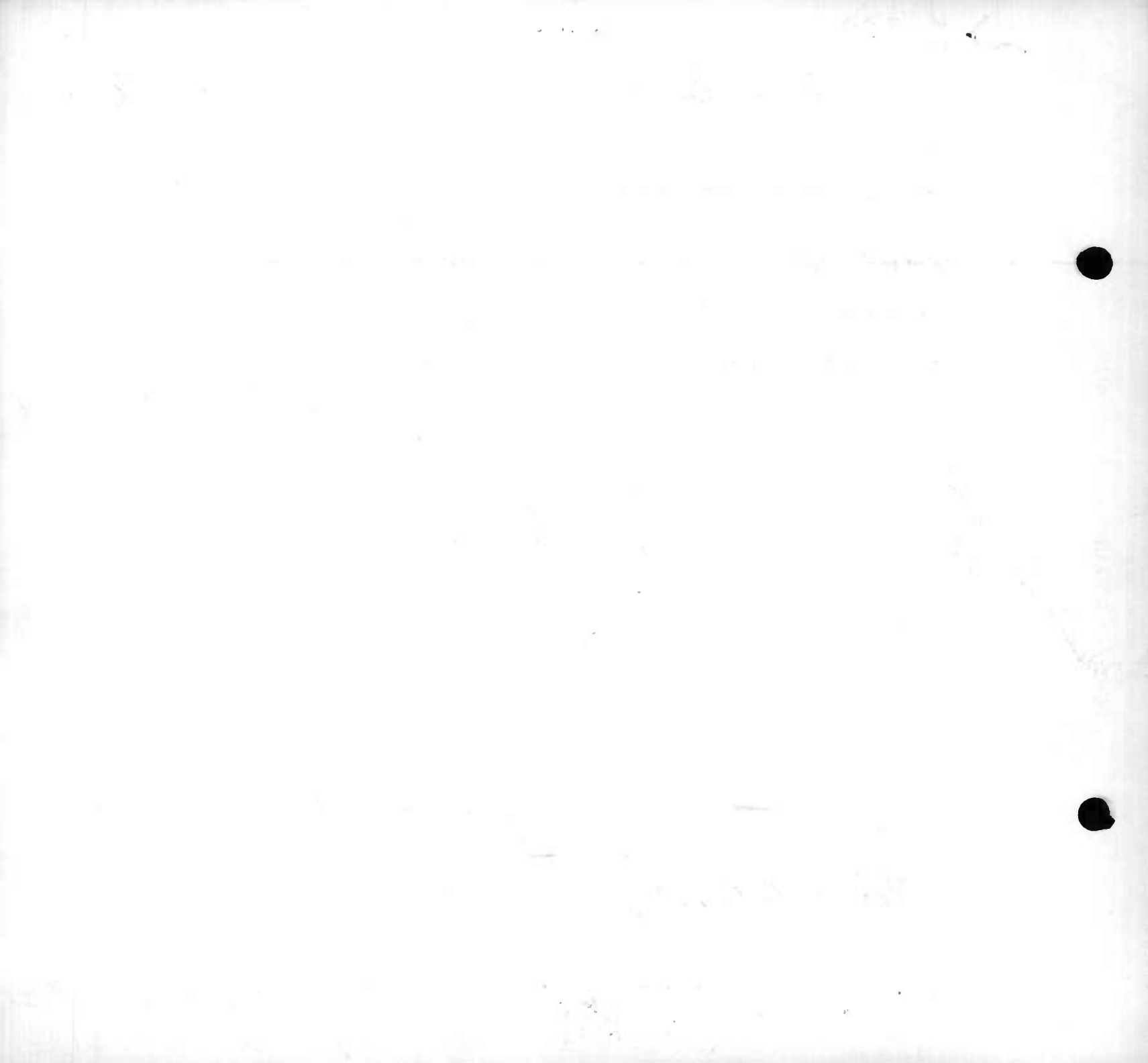
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5530			
P-652 70 5530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) LAWRENCE PRINCE, JR.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 25 70 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 5 25 1970 9:06 A.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 16 Nov. 1910				10. AGE (In years lost birthday) 59		11. BIRTHPLACE (State or foreign country) HUNGARY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME LAWRENCE PRINCE			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROJECT ADMINISTRATION				15. MOTHER'S MAIDEN NAME JULIA			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO. 162-09-6767		18. INFORMANT ADDRESS ANNA R. PRINCE 53 BLISTER ST. 21220	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5-25-70							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 29 MAY 70			
24C. NAME OF CEMETERY or CREMATORY GARDEN OF FAITH				24D. LOCATION (City, town, or county) (State) FULLERTON BALTO., Co. MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR ADDRESS LASSAHN FUNERAL HOME 7401 BELAIR RD.							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
70 5531		70 5531		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LENA BUTT</b>		
2. DATE AND HOUR OF DEATH <b>5/26/70 11:00 A. M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>GOULD NURSING HOME</b>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>GOULD NURSING HOME</b>		
C. CITY OR TOWN <b>PERRY HALL, MD</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>155A (Box) FORGE RD.</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 OCT. 1885</b>	9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WIFE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. Co.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE KAHL</b>		
14. MOTHER'S MAIDEN NAME <b>MARY FERNKAS</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212-16-5743</b>		17. INFORMANT <b>MRS. IRENE KRAFT PERRY HALL, MD. 21128</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Septicemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Large Sacral Decubitus Ulcer</b>		DUE TO, OR AS A CONSEQUENCE OF: <b>1 month</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Incontinence + Asphyxia</b>				
19A. DATE OF OPERATION <b>4/23/70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Removal of Daughter's</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home of Daughter</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Box 155A Forge Rd</b>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>4/23/70 AM</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Fell at Home</b>		
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>4/23/70</b> to <b>5/26/70</b> that (I) (we) last saw the deceased alive on <b>5/23/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Alvin B Bradley</b>		23B. DATE SIGNED <b>5/26/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Alvin B Bradley</b>
23D. ADDRESS <b>LASSAN FUNERAL HOME 7401 BELAIR RD.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>29 MAY 70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH</b>	24D. LOCATION (City, town, or county) (State) <b>FULLERTON BALTO. Co. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Charles E. Taylor</b>		





# FUNERAL DIRECTOR: IMPORTANT

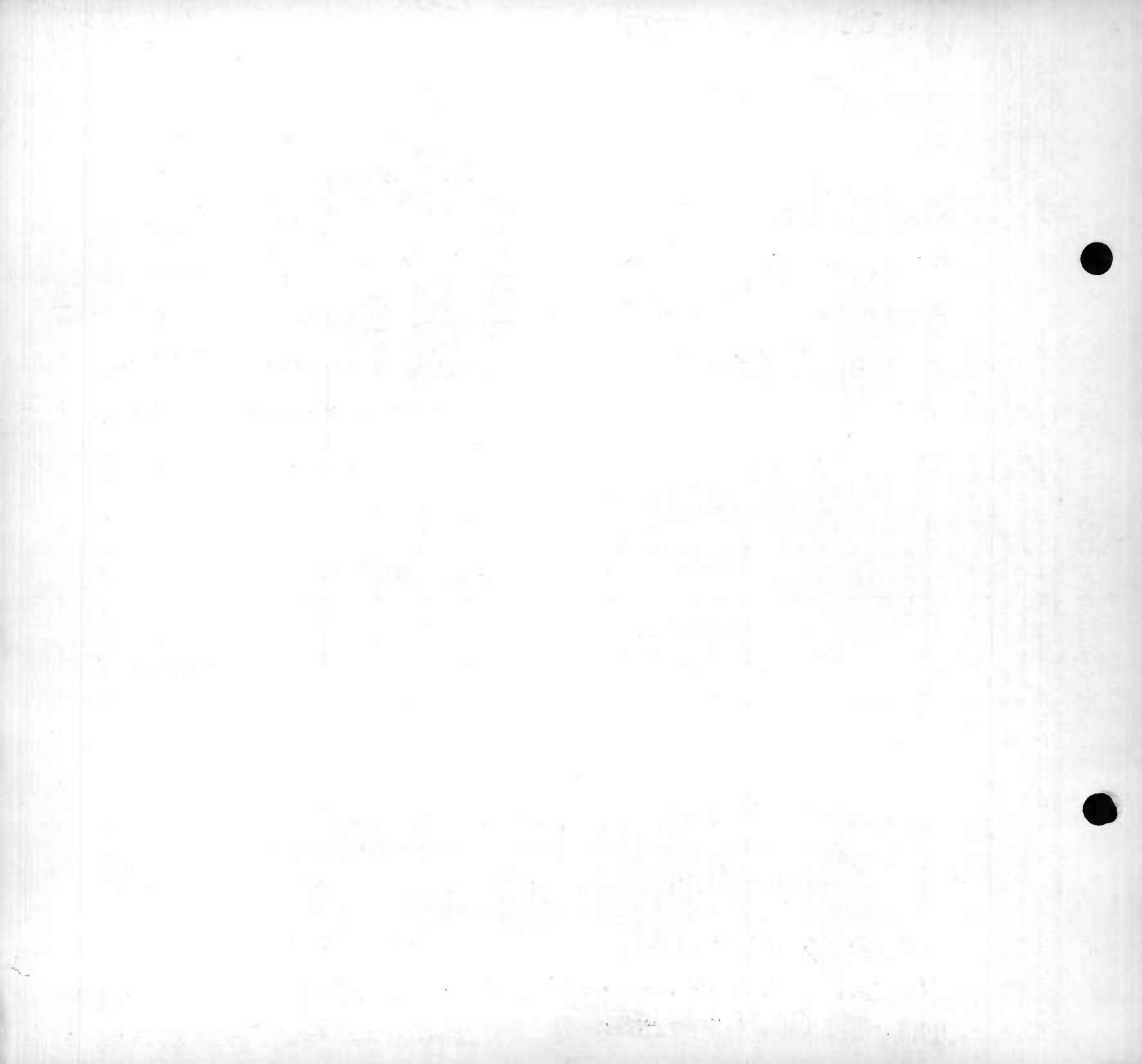
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-650		70 5532		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5532	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MARY---KRONM</b> Mary C. Krumm			
2. DATE AND HOUR OF DEATH <b>5/26/70.</b> <b>2:15 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp., 730 Ashburton St.</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>6-5-70</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3658 Clifmar Rd.</b>			
5. SEX <b>F.</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-76</b>	9. AGE (In years last birthday) <b>93.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown JOHN J. BAUSMAN</b>				14. MOTHER'S MAIDEN NAME <b>Unknown MARY E. SWEEM</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-48-0645</b>		17. INFORMANT <b>MARY Tewes</b>		ADDRESS <b>Same</b>	
18. <b>4-12-41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral Arteriosclerosis</b> <b>Chronic Brain Syndrome. 12 days.</b> <b>ASCVD.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days.</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Senility.</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>—</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (Approx.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5/14/1970</b> to <b>5/26/1970</b> , that (I) (we) last saw the deceased alive on <b>5/26/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Subash C. Ahuja M.D.</b>				23B. DATE SIGNED <b>5/26/70.</b>		23C. PHYSICIAN'S NAME (Type) <b>SUBASH C. AHUJA. M.D.</b>	
23D. ADDRESS <b>Lutheran Hosp. Balt. MD.</b>		23E. DEGREE <b>DEGREE</b>		23F. ADDRESS <b>Loring Byers 8728 Liberty Rd. Randallstown</b>		23G. DEGREE <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Subash C. Ahuja</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>		25D. ADDRESS <b>8728 Liberty Rd. Randallstown</b>	



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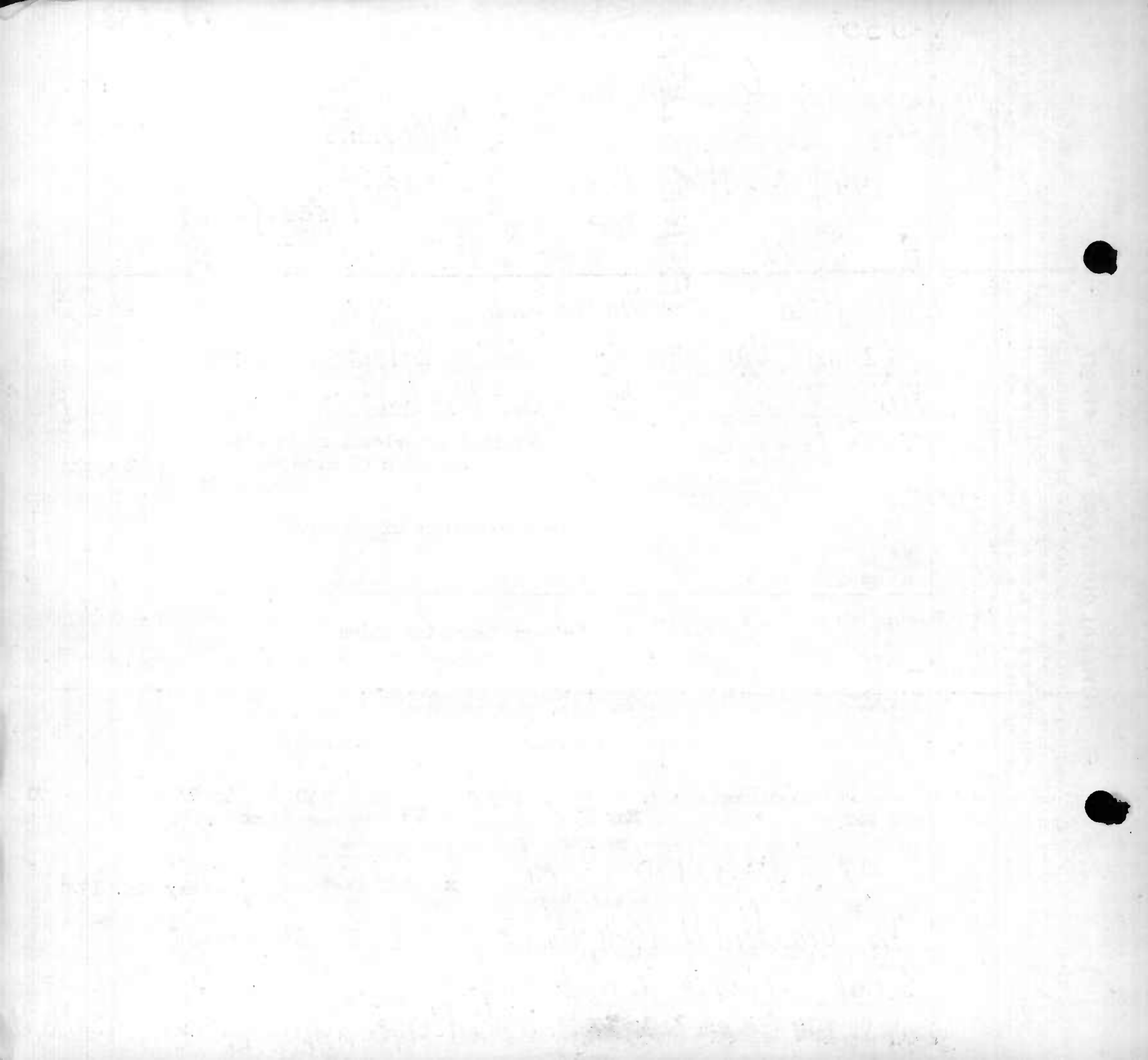
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5533</span>	
L-500		70 5533		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John H. Loney</i>		2. DATE AND HOUR OF DEATH <i>5/27/70</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>2215 Wicomico St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Maintenance</i>		8. DATE OF BIRTH <i>6/20/09</i> 9. AGE (In years last birthday) <i>60</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Lewis H. Loney</i>		14. MOTHER'S MAIDEN NAME <i>Clara B. Martino</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John L. Loney</i> ADDRESS <i>2007 Holling Fern</i>	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Acute coronary occlusion in minutes</i> DUE TO, OR AS A CONSEQUENCE OF: <i>HCD</i>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>years</i> <i>virus infection</i> <i>days</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1965</i> 19 <i>May 20</i> 19 <i>70</i> , that (I) (we) lost saw the deceased alive on <i>May 20</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Henry Armanas</i>		23B. DATE SIGNED <i>5/28/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. Henry Armanas</i>	
23D. ADDRESS <i>1934 Wilkins Ave</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>			
24B. DATE <i>6/11/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Louder Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Ambras &amp; Inc</i> ADDRESS <i>1328 Sulphur Sp Rd</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

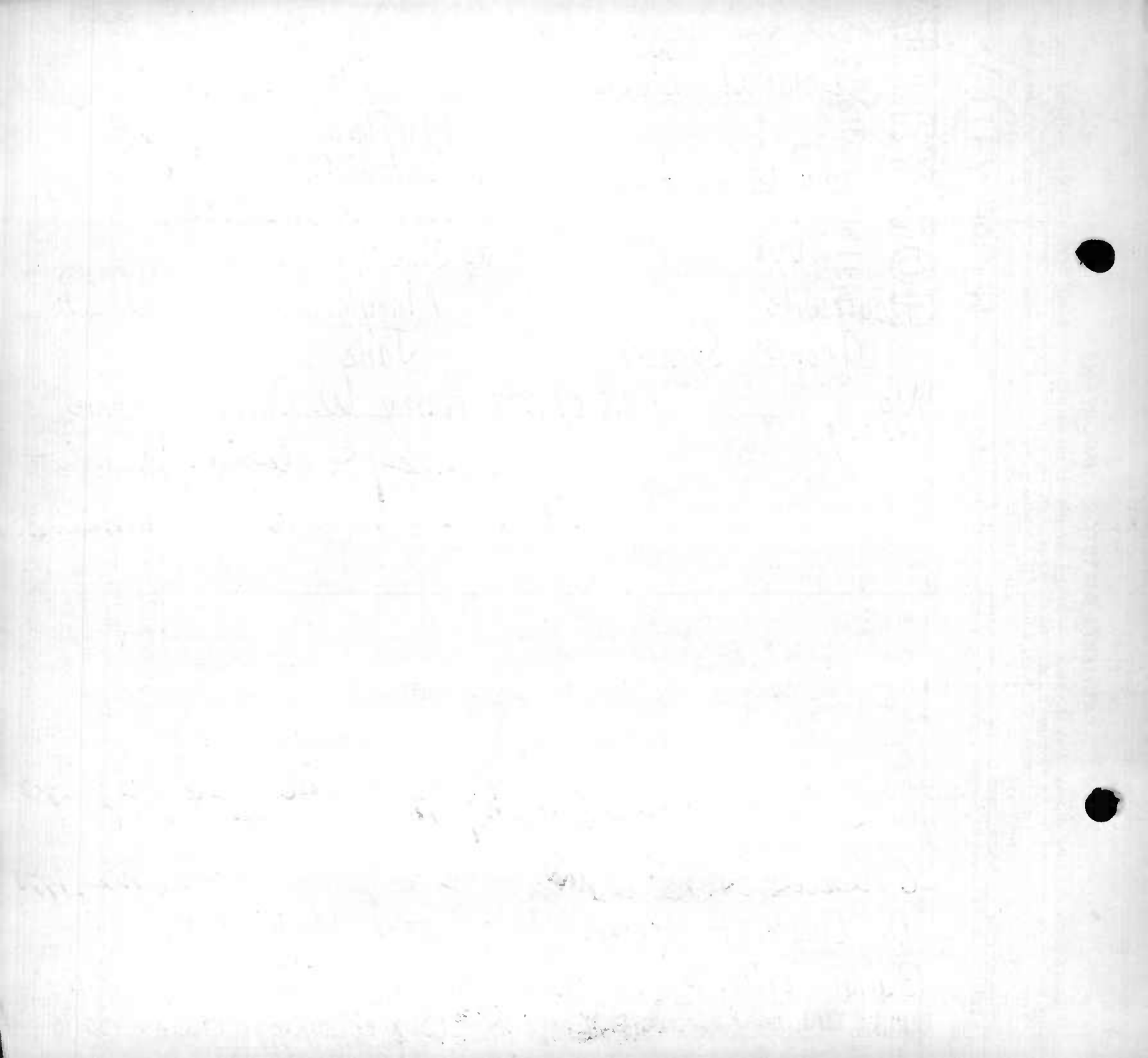
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5534</span>	
V-535		70 5534		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Nancy C. Van den Berg</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">May 24, 1970 8:15 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">00 1449 Medfield Ave.</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span>		B. COUNTY <span style="font-size: 1.2em;">Harford</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">Aberdeen</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">1 Paradise Road</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9 June 1890</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">79</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Dept Head</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Aberdeen Pro Grounds</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Tenn.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Yzaak Van den Berg</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Silvia M. Mayo</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220 22 0565</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs Robt Green Jr.</span>	
18. <span style="font-size: 1.2em;">433.9 I</span>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebral arteriosclerosis with question of cerebral thrombosis		2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Dehydration causing fever</span>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Urinary tract infection			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>observed</del> attended the deceased from <span style="font-size: 1.2em;">May 8</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">May 24</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) <del>last</del> saw the deceased alive on <span style="font-size: 1.2em;">May 23</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Crawford N Kirkpatrick Jr. MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">May 25, 1970</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Crawford N. Kirkpatrick Jr.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">6 E Eager St.</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">27 May '70</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Druid Ridge</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Pikesville, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 1 1970</span>	
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Borgee Funeral Home, Balto, Md.</span>		25D. ADDRESS <span style="font-size: 1.2em;">Baltimore, Md.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5535
CERTIFICATE OF DEATH				REG. NO. 70 5535
D-120 70 5535				
1. NAME OF DECEASED (Type or Print) <b>Lola U. Davis</b>		2. DATE AND HOUR OF DEATH <b>May 24, 1970</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1014 Union Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1307</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1014 Union Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 June 1884</b> 85 9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Spencer</b>		
14. MOTHER'S MAIDEN NAME <b>Jane</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>215 54 1277</b>		17. INFORMANT <b>Harry W. Davis</b> ADDRESS <b>same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/10/9 I</b> <b>Cornary Occlusion</b> <b>Anterior Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>10 years</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 1946</b> to <b>24 May 1970</b> , that (I) (we) lost saw the deceased alive on <b>24 May 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Charles H. Reier MD.</b>		23B. DATE SIGNED <b>26 May 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr Charles H. Reier</b>
23D. ADDRESS <b>6701 York Road</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>27 May 70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>
24D. LOCATION (City, town, or county) (State) <b>Balto Co., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt</b>		25C. FUNERAL DIRECTOR <b>Supper Funeral Home</b> ADDRESS <b>Balto Md</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5536</u>	
A-621		70 5536		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Florence G. Argabright</u>		2. DATE AND HOUR OF DEATH <u>May 26, 1970</u> <u>4:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 6000 Roland Ave.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>2713</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>6000 Roland Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Feb. 1886</u>	9. AGE (In years lost birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Bailey</u>		14. MOTHER'S MARDEN NAME <u>Katherine</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 46 7426</u>		17. INFORMANT <u>Eldred B. Ross</u> ADDRESS <u>408 Timonium Rd.</u>	
18. <u>1886</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Urinary Bladder</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>June 19 68</u> to <u>May 26 19 70</u> , that (I) (we) last saw the deceased alive on <u>May 20 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dr. William G. Helfrich</u> MD		23B. DATE SIGNED <u>27 May 70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. William G. Helfrich</u>		23D. ADDRESS <u>5006 Roland Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>30 May 70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Oak Hall, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Burgess Funeral Home, Balto, Md.</u>		25D. ADDRESS <u>Bu. Home, N. Avenue Dr.</u>			



# FUNERAL DIRECTOR: IMPORTANT

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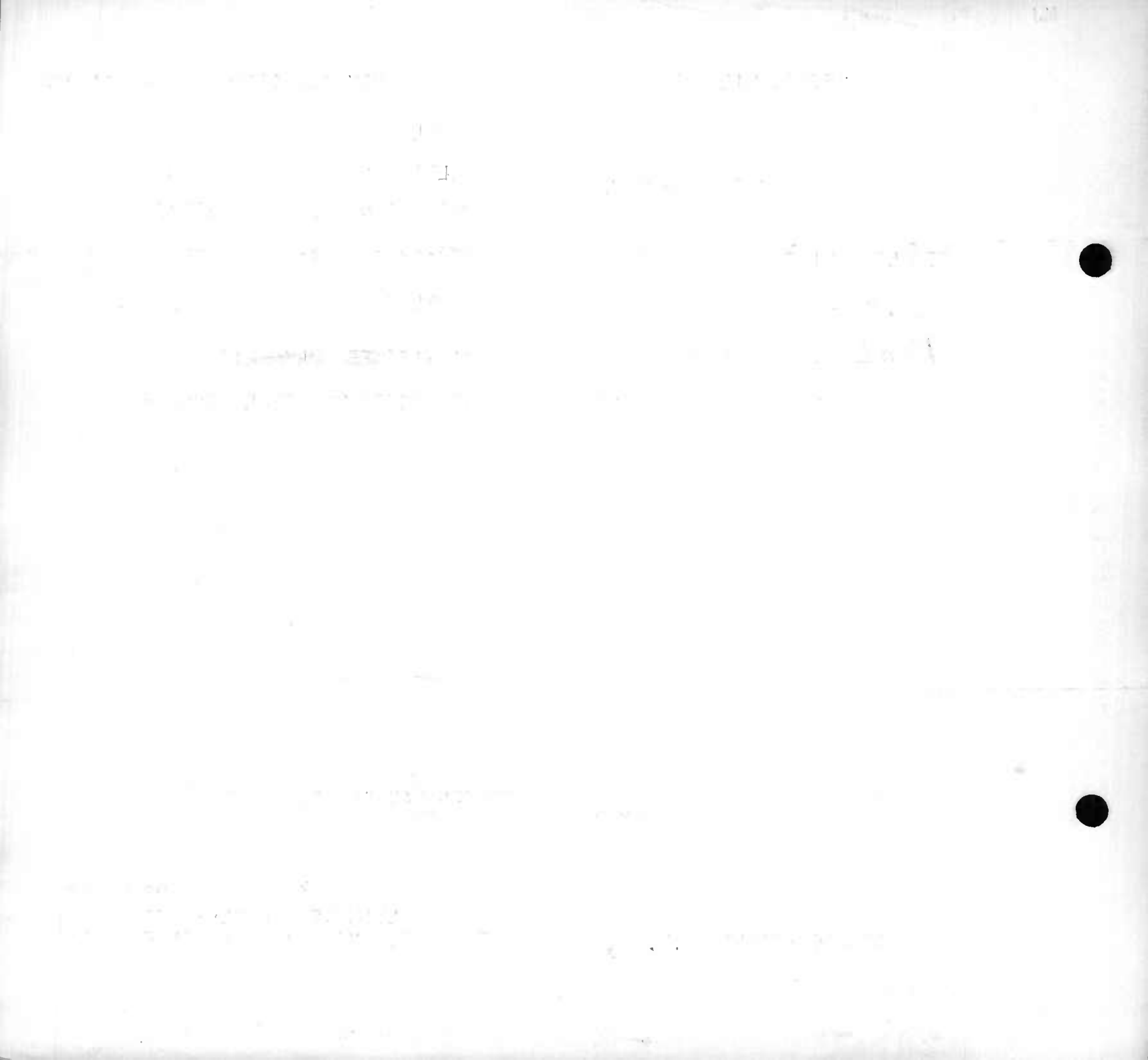
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5537	
8-352 70 5537		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edith T. Stengel</i>		2. DATE AND HOUR OF DEATH <i>May 24, 1970</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2755</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Wesley Home</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2211 W. Rogers Ave.</i>		5. SEX <i>F</i>		6. RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>17 Jan 1878</i>		9. AGE (In years last birthday) <i>92</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wells Emory Tolson</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Chew Eareekson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218 20 8640A</i>		17. INFORMANT <i>Wesley Home</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.41</i>		CAUSE OF DEATH <i>Arterio-sclerotic cardiovascular disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>18 June 1968</i> to <i>24 May 1970</i> , that (I) (we) last saw the deceased alive on <i>19 May 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John W. Barnaby</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>26 May 70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. John W. Barnaby</i>		23D. ADDRESS <i>1652 E. Belvedere Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>28 May 70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION <i>Balto, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Barber, R.D.</i>	
25C. FUNERAL DIRECTOR <i>Borgee Funeral Home</i>		25D. ADDRESS <i>Walter J. Borgee</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5538</u>	
BIRTH NO. <u>70 5538</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SEETS, HILDA M.</u>		2. DATE AND HOUR OF DEATH <u>MAY 26, 1970</u> <u>11:25A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2551</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> <u>ST. AGNES HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>08/18/08</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>KARL FULKOSKI</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE (NE FULKOSKI)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u>	
18. <u>750.0 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>suspected @ middle cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>arteriosclerosis, hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>90 hrs.</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>XXXXXX MAY 24, 1970</u> to <u>MAY 26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MAY 26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George Patrick M.D.</u>		23B. DATE SIGNED <u>05 26 70</u>		23C. PHYSICIAN'S NAME (Type) <u>GEORGE PATRICK M.D.</u>	
23D. ADDRESS <u>BALTIMORE, MARYLAND 21229</u> <u>ST. AGNES HOSP; CATON &amp; WILKENS AVES.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>5/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louisa PK Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>E. S. Mac Nabb</u>	
25D. ADDRESS <u>301 Frederick Rd</u> <u>Balt. Md.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

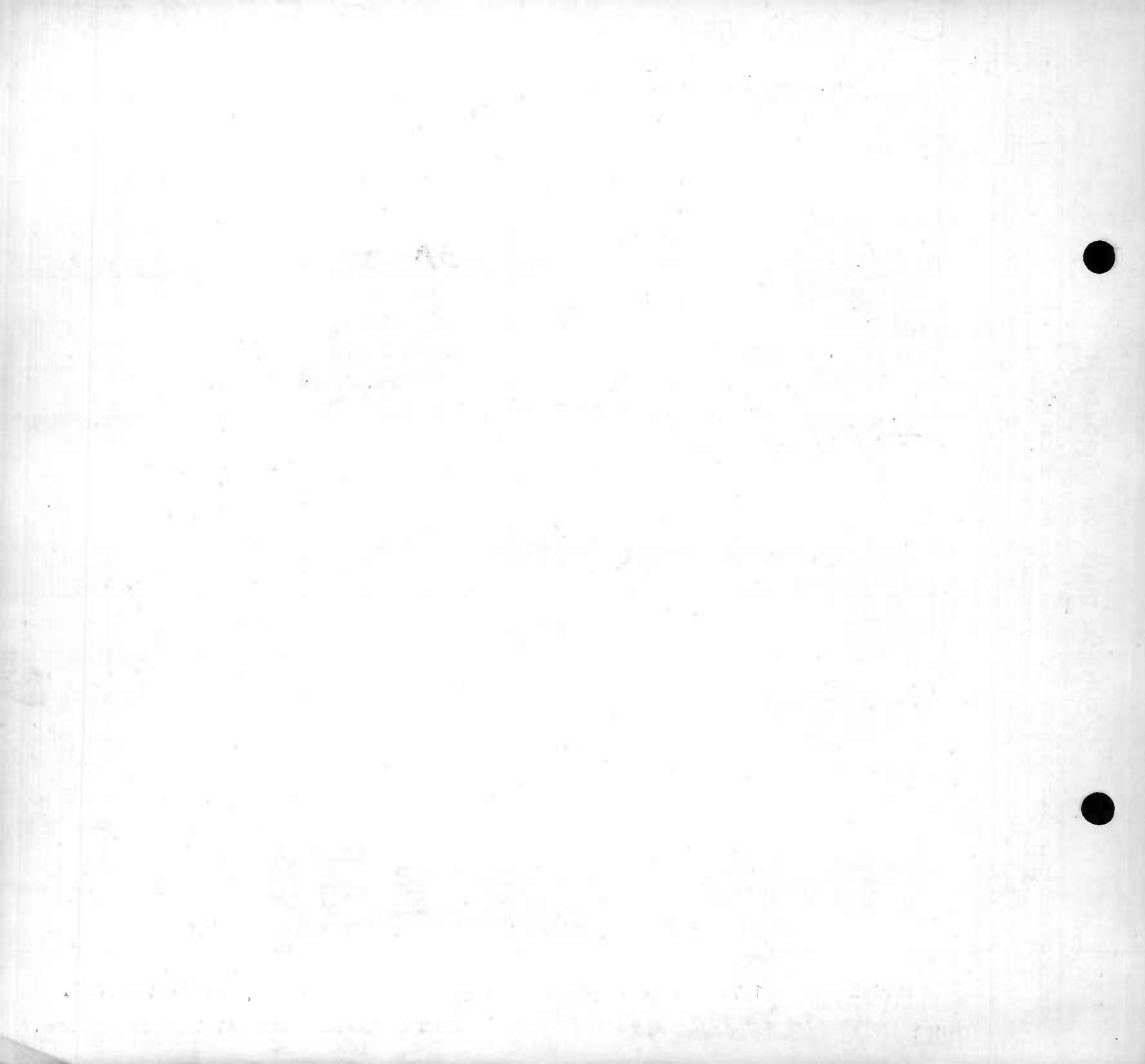
BALTIMORE CITY HEALTH DEPARTMENT														
B-600 70 5539					CERTIFICATE OF DEATH					REG. NO. 70 5539				
1. NAME OF DECEASED (Type or Print) <b>BURR, DORIS</b>					2. DATE AND HOUR OF DEATH <b>MAY 29 1970 7<sup>20</sup> P.M.</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1302</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER									
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/27/23</b>		9. AGE (In years last birthday) <b>46</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>MD</b>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>HERBERT SOULMAN</b>					14. MOTHER'S MAIDEN NAME <b>GERTRUDE MALL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>219-12-6922</b>					17. INFORMANT <b>Calvin Burr</b> ADDRESS <b>Helen Chase 941 Ellicott Dr</b>				
18. I <b>593.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> <b>ROWN FAILURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that <del>(the)</del> (this hospital) attended the deceased from <b>4/16/70</b> 19 to <b>5/29/70</b> 19 that (I) <del>(we)</del> last saw the deceased alive on <b>5/29/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.														
23A. SIGNATURE <b>Frank N. Turner M.D.</b>										23B. DATE SIGNED <b>5/29/70</b>				
23C. PHYSICIAN'S NAME (Type) <b>FRANK N. TURNER</b>										23D. ADDRESS <b>3422 BEACH DRIVE, MIDDLERIVER MD.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>6/2/70</b>					24C. NAME OF CEMETERY OR CREMATORY <b>Wm. Ashbury Cem. Balt.</b>				
24D. LOCATION (City, town, or county) (State) <b>Maryland</b>					25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>				
25C. FUNERAL DIRECTOR <b>Earl R. Moore</b>					25D. ADDRESS <b>1827 W. North Ave</b>									





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 5540</span>	
C-462 70 5540					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Clarke, Mildred C.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5-29-70</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2037</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Lutheran Hospital</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">514 Edgewood Street</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1-31-20</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">50</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">typist</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Reliable Liquors</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Russell H. Elliott</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Frances Bourne</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-14-9922</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Lewis Trescott</span> ADDRESS <span style="font-size: 1.2em;">Dangle - 4419, Robey Rd.</span>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><span style="font-size: 1.2em;">436.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Respiratory failure</span></p> <p>(B) <span style="font-size: 1.2em;">CVA</span> <span style="font-size: 1.2em;">Cerebral</span> <span style="font-size: 1.2em;">subarachnoid</span> <span style="font-size: 1.2em;">haze</span> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/25/70</span> to <span style="font-size: 1.2em;">5/29/70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/29/70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Kurn</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/29/70</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">KYI KYI LWIN</span>		23D. ADDRESS <span style="font-size: 1.2em;">Lutheran Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/1/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Meadowridge Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Dorsey Md. Washington Blvd.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 1 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, Jr.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Witzke Funeral Home 4101 Edmondson Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>S-530</b>		70 5541		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. <b>70 5541</b>	
1. NAME OF DECEASED (Type or Print) <b>SMITH, BENTON Byrne</b>				2. DATE AND HOUR OF DEATH <b>MAY 27 - 1970 4:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>1/3 So. Baltimore Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1/3 So. Baltimore Hosp.</b>				C. CITY OR TOWN <b>Linthicum Hgts</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22, 1924</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Smith</b>				14. MOTHER'S MAIDEN NAME <b>Martha Simms</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II 282-20-2722</b>		17. INFORMANT <b>Mrs. Myrtle Bucklew (sister)</b>		ADDRESS <b>Rt #10 - Box #170 Hanover, Md.</b>	
18. <b>5-62-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral Bronchopneumonia</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>7 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>subdiaphragmatic abscess</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>2 months</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>duodenal ulcer</b>				(C) _____			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 23 - 1970</b> to <b>MAY 27 1970</b> that (I) (we) last saw the deceased alive on <b>MAY 27 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. A. Villapana</b>				23B. DATE SIGNED <b>MAY 27 - 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>A. A. VILLAPANIA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>June 1, 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gordons Cemetery</b>	
24D. LOCATION <b>Reedsville, RFD, W. Va.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>R. V. Singleton</b>				25D. ADDRESS <b>Singletons Funeral Home</b>		25E. ADDRESS <b>618 N. Burnie, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5542</u>	
P626 70 5542		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gertie Parker		May 25, 1970 1:15 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 631 W. Lafayette Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old Age		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charles County Md	
13. FATHER'S NAME Philip Hawkins			12. CITIZEN OF WHAT COUNTRY? U S A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. D. M. Dixon-Pastor	
18. <u>320.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH <u>Microvascular Meningitis</u> (A) IMMEDIATE CAUSE <u>Longestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>? 2 days</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 23, 1970</u> to <u>May 25, 1970</u> that (I) (we) last saw the deceased alive on <u>May 25, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Saunders</u>			23B. DATE SIGNED 5-25-70		
23C. PHYSICIAN'S NAME (Type) Elijah Saunders, M. D.			23D. ADDRESS 1514 Division Street Balto., Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/1/70		MT Auburn Cemetery Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5543</u>	
<div style="display: flex; justify-content: space-between;"> <span>M-234</span> <span>70 5543</span> <span>BIRTH NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Joe McDowell</u>			2. DATE AND HOUR OF DEATH <u>5/28/70</u> <u>5<sup>30</sup></u> <u>4<sup>M</sup></u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>535 Fulton Ave</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-11</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months: Oays: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOE MCDOWELL</u>			14. MOTHER'S MAIDEN NAME <u>LILLIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS LIZZIE MCDOWELL, SAME</u>
18. <u>5-7-70</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Perforated duodenal hematoma</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Pancreatitis</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>1 wk.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>35 25/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pancreatitis - Per Duodenal</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> 19 <u>70</u> to <u>5/28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>De Witt Kemp</u> MD DEGREE			23B. DATE SIGNED <u>5/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>De Witt Kemp</u> MD DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/30/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lynchburg</u>	
24D. LOCATION (City, town, or county) (State) <u>South Carolina</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W north</u>			

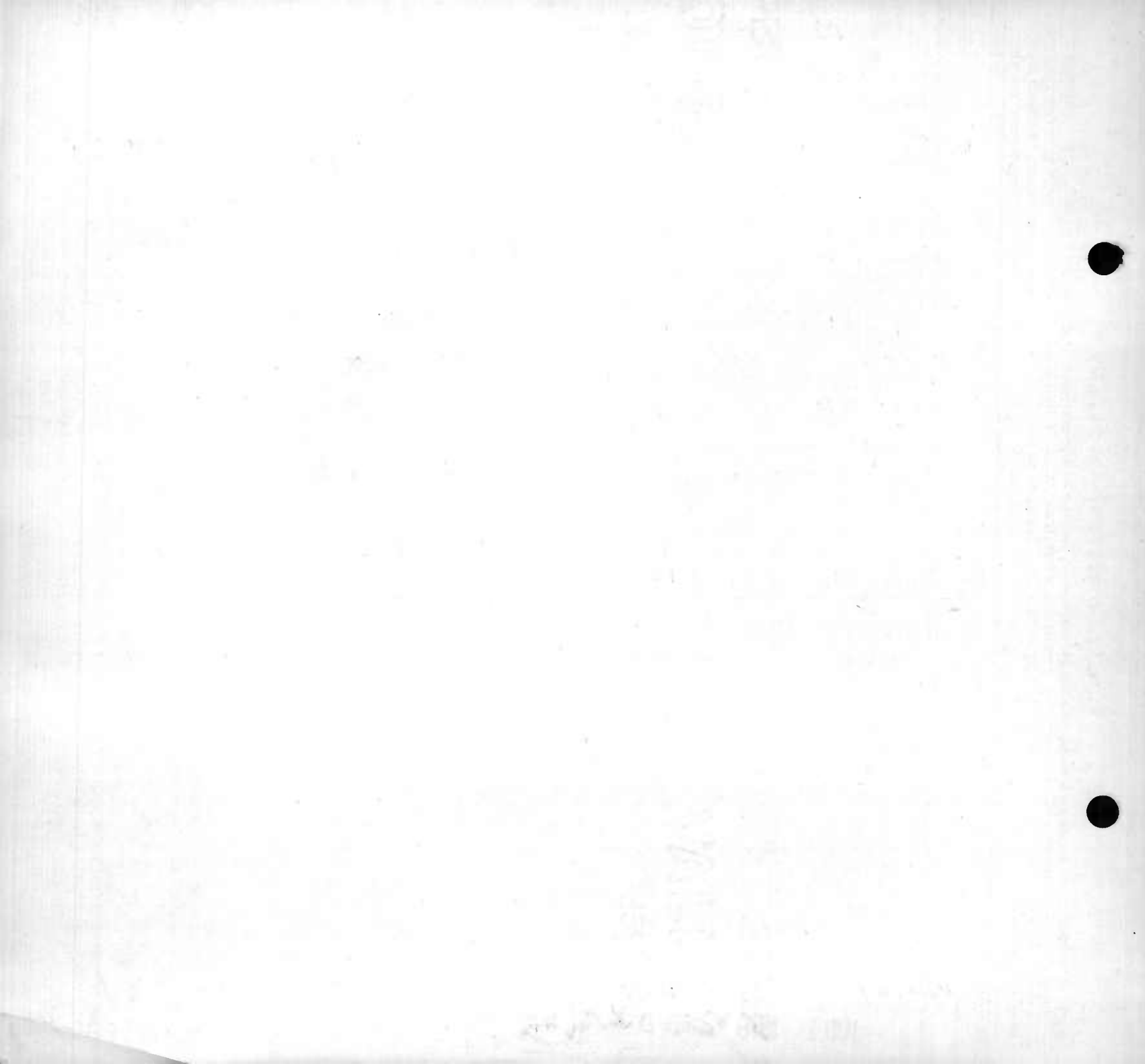




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5544	
BIRTH NO. 70 5544		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES CAREY		2. DATE AND HOUR OF DEATH 11 45 pm 5/17/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Ruthereen Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1547 C. CITY OR TOWN Belkmore 21216 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2121 KOKOLA			
5. SEX Male	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-23-1919	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Allen Carey		14. MOTHER'S MAIDEN NAME Rebecca Coleman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/23/44 - 1/2/46		16. SOCIAL SECURITY NO. 214-12-9104		17. INFORMANT Rebecca Colbeck (sister) Address same as above	
18. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bleeding esophageal varices (B) Cirrhosis liver (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/16/70 1970 to 5/17 1970, that (I) (we) last saw the deceased alive on 11 45 pm 5/17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prathima Bose M.D.		23B. DATE SIGNED 5/17/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) PRATHIMA BOSE M.D.		23D. ADDRESS Ruthereen Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/22/70		24C. NAME OF CEMETERY OR CREMATORY BALG. NATIONAL CEMETARY	
24D. LOCATION BALTIMORE, MD		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR J. B. Johnson 1900 E. A. W. P. Balt. Md.	



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70 5545

BALTIMORE CITY HEALTH DEPARTMENT

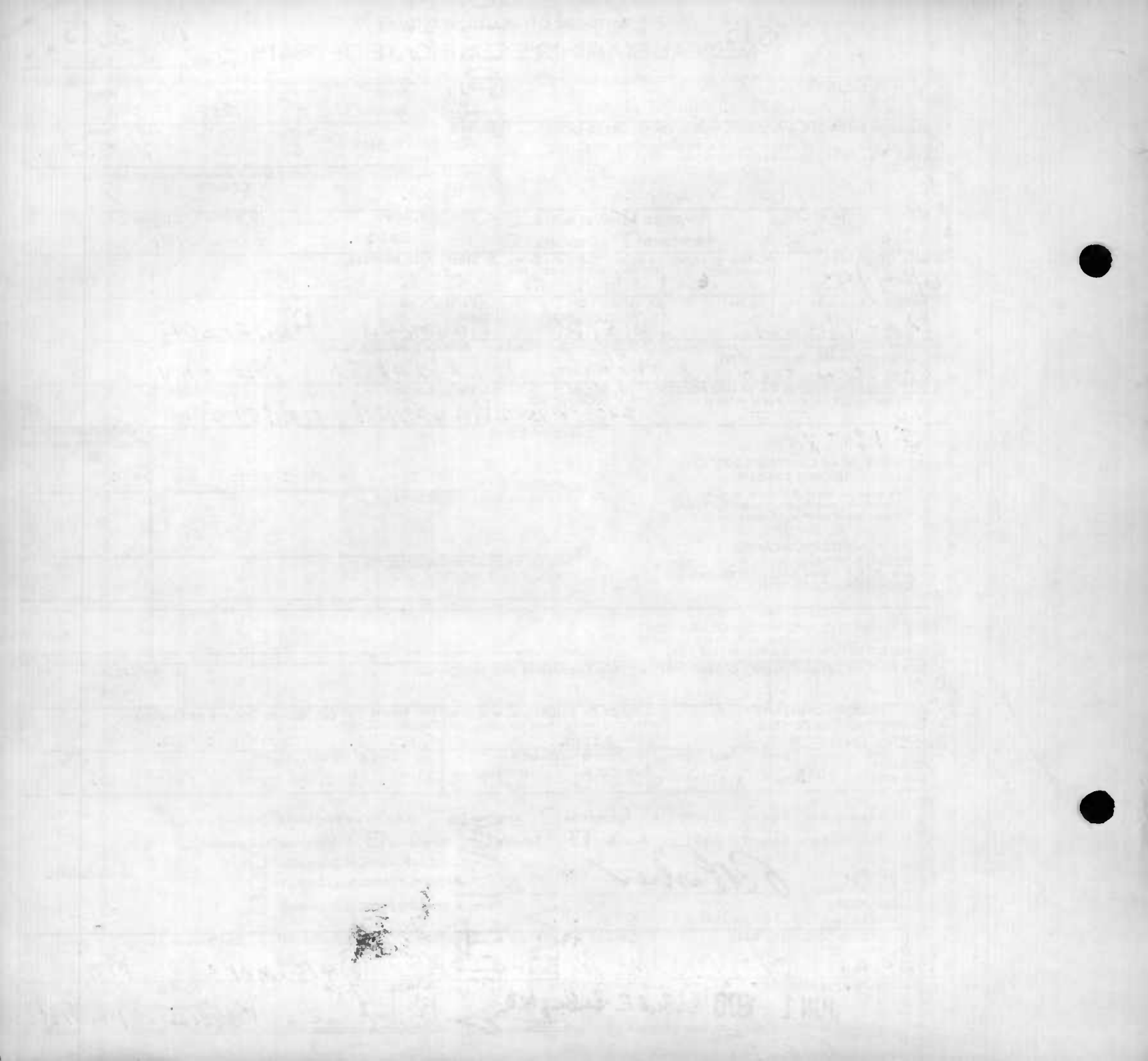
70 5545

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LAWRENCE D. ANDERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>5 25 70</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>5 25 1970 2:17 A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/24/43</b>		10. AGE (In years last birthday) <b>26</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond Anderson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION</b>	
15. MOTHER'S MAIDEN NAME <b>Elizabeth Murphy</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>420-38-9352</b>		18. INFORMANT ADDRESS <b>RAYMOND Anderson</b>	
19. CAUSE OF DEATH <b>E965 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Multiple gunshot wounds of chest &amp; abdomen</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>24th St. &amp; Greenmount Ave.</b>		22D. TIME OF INJURY (APPROX.) <b>5-25-70 1:40 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. shot by unknown assailant.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>R. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>5-25-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/29/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MC. ANDRWN Cem</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>J. B. Janner</b>		ADDRESS <b>Baltimore 177 Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5546</b>	
BIRTH NO. <b>70 5546</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Beverly Stephens</b>		2. DATE AND HOUR OF DEATH <b>5-29-70 5 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1607</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp. of Md.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>46 1213 Poplar Grove St.</b>					
5. SEX <b>F</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-08</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Moses Reid</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Bellings</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mildred Keys 1213 Poplar Gr.</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>pulmonary edema</b> (B) <b>Congestive heart failure and arrhythmia</b> (C) <b>A.S.C.V</b>  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Uremia</b>			
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>no injury</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>no injury</b>	
21D. TIME OF INJURY (APPROX.) <b>no injury</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>no injury</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>5-28 1970</b> to <b>5-29 1970</b> , that (I) (we) last saw the deceased alive on <b>5-29 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mehrdad Jalali</b>		23B. DATE SIGNED <b>5-29-70</b>		23C. PHYSICIAN'S NAME (Type) <b>MEHRDAD JALALI</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-3-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION <b>Norfolk, Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Talbot, M.D.</b>		25C. FUNERAL DIRECTOR <b>U. R. Bailey</b>			
25D. ADDRESS <b>Kellogg Bldg. 1348 Calhoun St.</b>					

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12/11/1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

600

70 5547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 5547

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY ELLEN GRAY

2. DATE AND HOUR OF DEATH

5/29/70

12:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

LAKE DRIVE NURSING HOME

C. CITY OR TOWN

Baltimore, MD

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

LAKE DRIVE NURSING HOME 1509

5. SEX

F

6. RACE

Negroid

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

9/27/89

9. AGE (in years last birthday)

80

If Under 1 Mo. If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

NO

16. SOCIAL SECURITY NO.

330-30-2398

17. INFORMANT

Morrison Gray 706 NEWINGTON A.

ADDRESS

18. 599.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Gram negative bacteremia shock

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Urinary tract infection

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/25 1970 to 5/29 1970 that (I) (we) last saw the deceased alive on 5/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MAYURKEE KHONGCHAROENSUK, M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

5/29/70

23C. PHYSICIAN'S NAME (Type)

MAYURKEE KHONGCHAROENSUK, M.D.

DEGREE

23D. ADDRESS

Bon Secours Hosp. Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-2-70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 1 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

W. Bailey Kelson P.H. 1348 Calhoun St.

ADDRESS

2403 Taibot Rd.

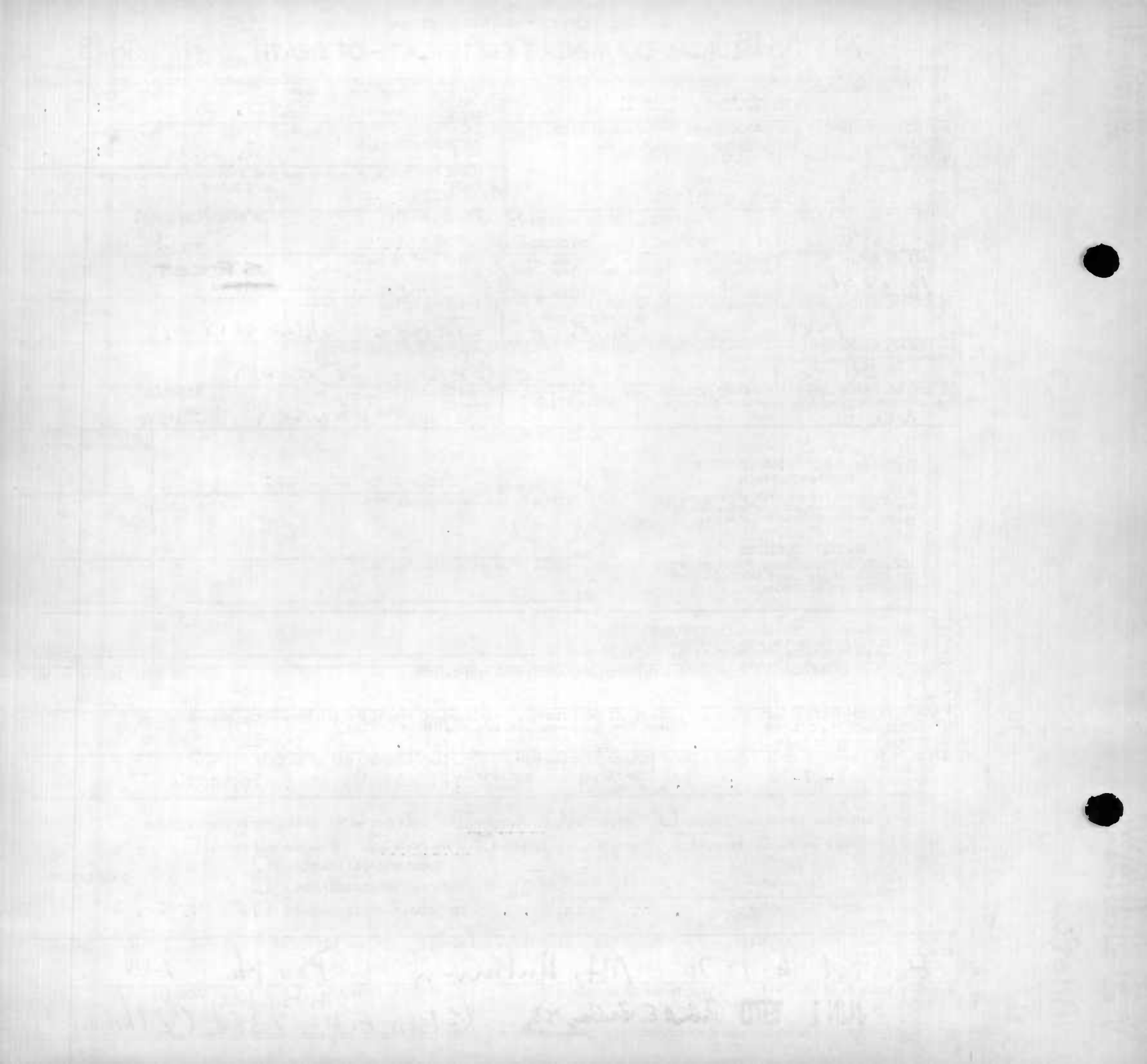


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>REGINALD JOHNSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 27, 1970 Hour 4:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year May 27, 1970 Hour 4:45 P. M.	
6. SEX <b>Male</b>		7. RACE <b>Negroid</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-5-50</b>		10. AGE (in years last birthday) <b>19</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>James Johnson</b>		15. MOTHER'S MAIDEN NAME <b>Bessie Brown</b>	
18. INFORMANT <b>James Johnson</b>		ADDRESS <b>Sam</b>	
19. CAUSE OF DEATH <b>E966 X</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Stabwound of chest</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>3 N. Ellamont Avenue 2006</b>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>5-27-70 4:15 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>May 28, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-1-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 1 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kelson F. H.</b>		ADDRESS <b>1348 Calhoun St.</b>	

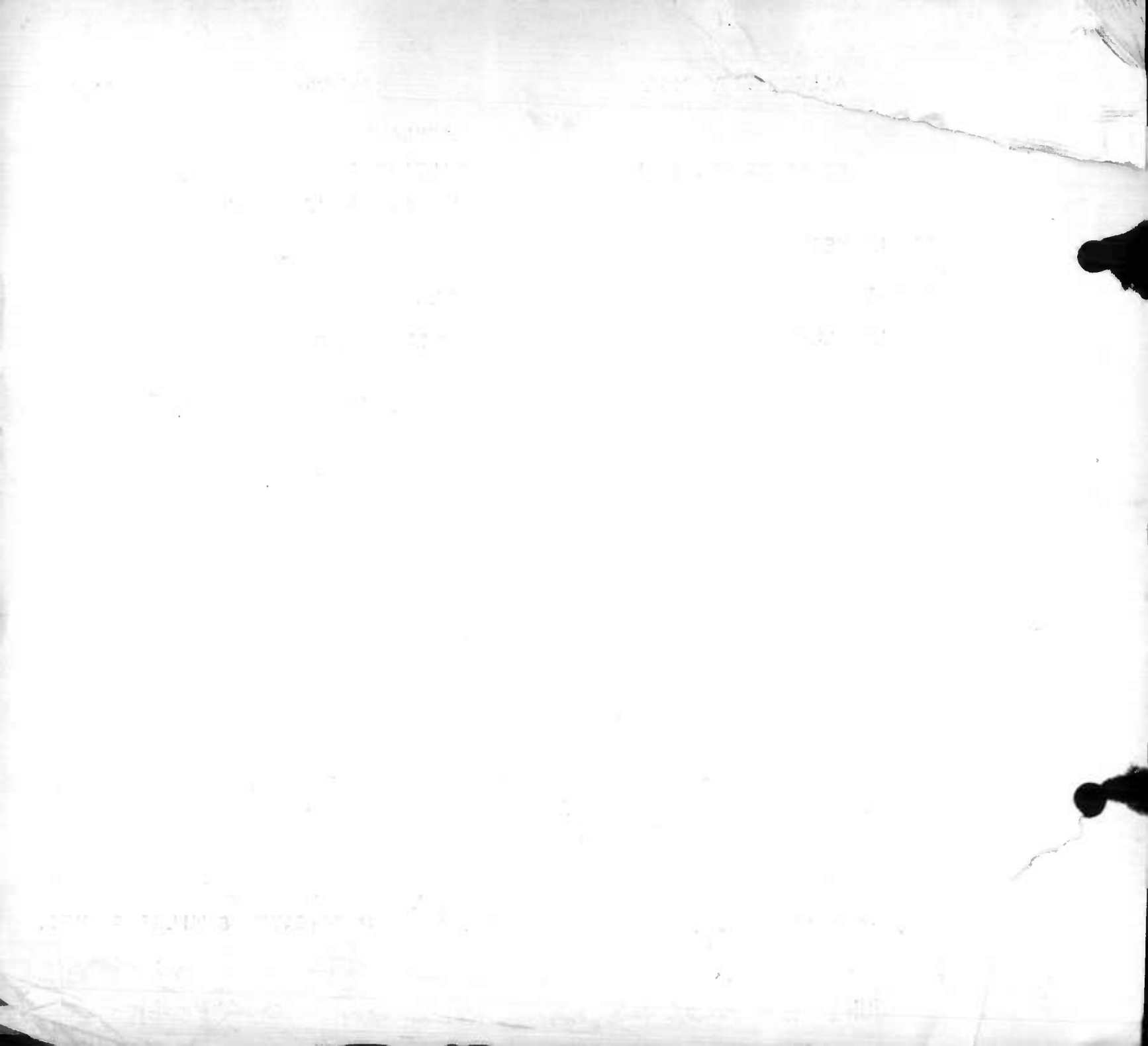


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 5549

BIRTH NO. 70 5549 70-09422		1. NAME OF DECEASED (Type or Print) ALLEN, BABY GIRL		2. DATE AND HOUR OF DEATH 5/28/70 11 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1512		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2604 SPRINGHILL AVENUE	
6. SEX FEMALE	7. RACE NEGROID	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 5 24 70	10. AGE (In years last birthday) 4	11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME RONALD ALLEN		14. MOTHER'S MAIDEN NAME MOZELLE HOLLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Ronald Allen	
ADDRESS SAME		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5/24/1970 to 5/28/1970 that (I) (we) last saw the deceased alive on 5/28/1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. De Castro - M.D.	
23B. DATE SIGNED 5/29/70		23C. PHYSICIAN'S NAME (Type) M. DE CASTRO, M.D.		23D. ADDRESS ALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-1-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	
24D. LOCATION (City, town, or county) (State) Balto. Md		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kelton F. R. Bailey		25D. ADDRESS 1348 Reardon St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5550</u>	
BIRTH NO. <u>70 5550</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MAURICE L. MOORE</u>			2. DATE AND HOUR OF DEATH <u>5/27/70</u> <u>5:55 PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1511</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>CEDARDALE RD 3800 #15</u>		
5. SEX <u>m</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/11</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School System</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles M. Moore</u>			14. MOTHER'S MAIDEN NAME <u>MABLE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>217-03-0060</u>		17. INFORMANT <u>CATHERINE MOORE - WIFE - SAME</u>
18. <u>582 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uraemia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>7</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>5/17/70</u> 19__ to <u>5/27/70</u> 19__ that (2) (we) last saw the deceased alive on <u>5/27/70</u> 19__ and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald D. Gaynor M.D.</u>			23B. DATE SIGNED <u>5/27/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Donald D. Gaynor M.D.</u>
23D. ADDRESS <u>SINAI HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>6-1-70</u>	24C. NAME of CEMETERY or CREMATORY <u>MT. AUBURN CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR & ADDRESS <u>KELSON F. W. 1348 N. CALHOUN ST.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

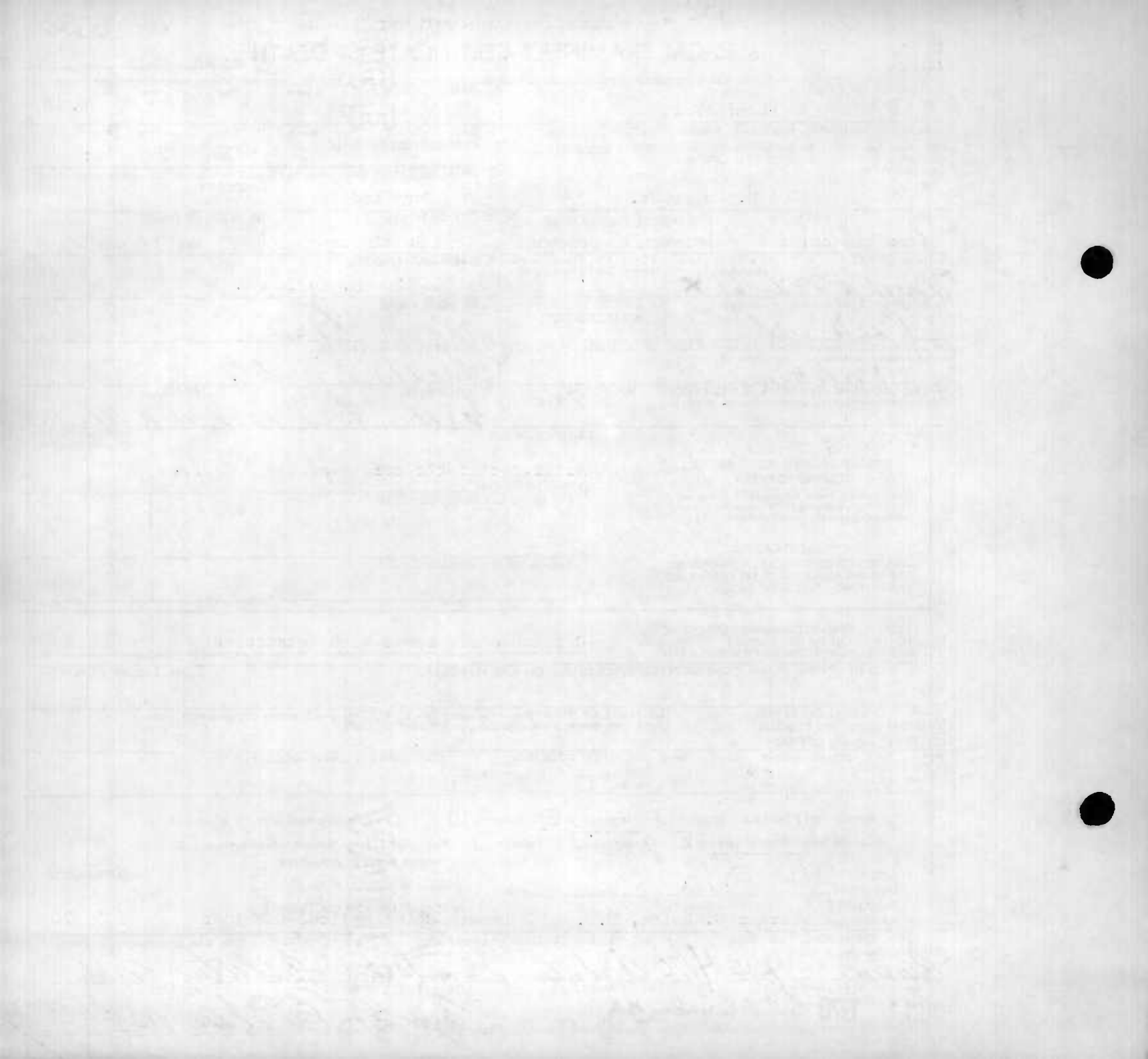
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5551</u>	
<div style="display: flex; justify-content: space-between;"> <span>S-000 70 5551</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Jack Shay</u>			2. DATE AND HOUR OF DEATH <u>25-May-70</u> <u>10:03</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>2506</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3629 Leo Street</u>		
5. SEX <u>White</u>	6. RACE <u>Male</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/03</u>	9. AGE (in years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-52-3198</u>		17. INFORMANT <u>Mrs. Gertrude Shay</u>	
				ADDRESS	
18. <u>250.91</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u>		<u>3 yrs</u>
			(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10+ yrs</u>
			(C) <u>Diabetes Mellitus</u>		<u>10+ yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Old Myocardial infarction</u>		<u>2+ yrs</u>
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) f(Month) f(Day) f(Year) f(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>23-May</u> 19 <u>70</u> to <u>25-May</u> 19 <u>70</u> that (U) (we) last saw the deceased alive on <u>25-May</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard E. Fisher MD</u>				23B. DATE SIGNED <u>26-May-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard E. Fisher MD</u>				23D. ADDRESS <u>South Baltimore General Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/28/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher MD</u>		25C. FUNERAL DIRECTOR <u>Joseph M. ...</u>			
25D. ADDRESS <u>263 S. ...</u>					





REG. NO.

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

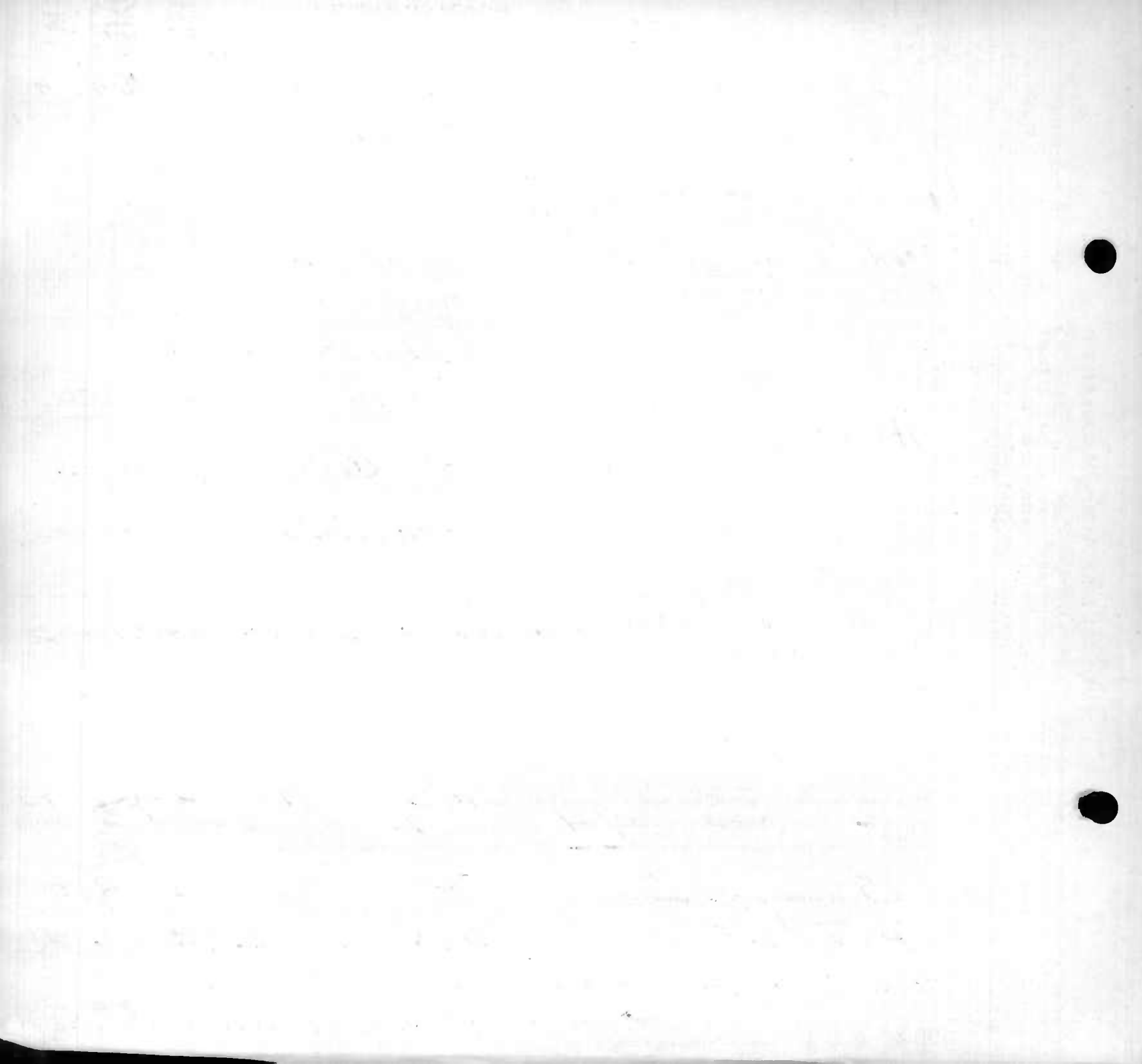
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5553</u>	
N-242 70 5553		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Mrs. Lela Nicholson</u>			2. DATE AND HOUR OF DEATH <u>5/28/70 11:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>			A. STATE <u>md.</u> B. COUNTY <u>909</u>		
C. CITY OR TOWN <u>Balto</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1717 Lamont Ave</u>					
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/17</u>	9. AGE (in years last birthday) <u>52</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beat Cleaner</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>md.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>Laura Enwels</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Kathleen Hanks</u>			ADDRESS		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial Infarction</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/28/70 19 70</u> to <u>5/28 19 70</u> that (I) (we) last saw the deceased alive on <u>5/28 19 70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis E. Gruyer</u>				23B. DATE SIGNED <u>5/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Taber, M.D.</u>				23D. ADDRESS <u>1129 N. Calver St.</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>6/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>	
24D. LOCATION <u>909 Calvary, Md.</u>		24E. CITY, TOWN, OR COUNTY <u>Baltimore</u>		24F. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>John H. Hanks</u>	
25D. ADDRESS <u>1129 N. Calver St.</u>					

Lamont Ave

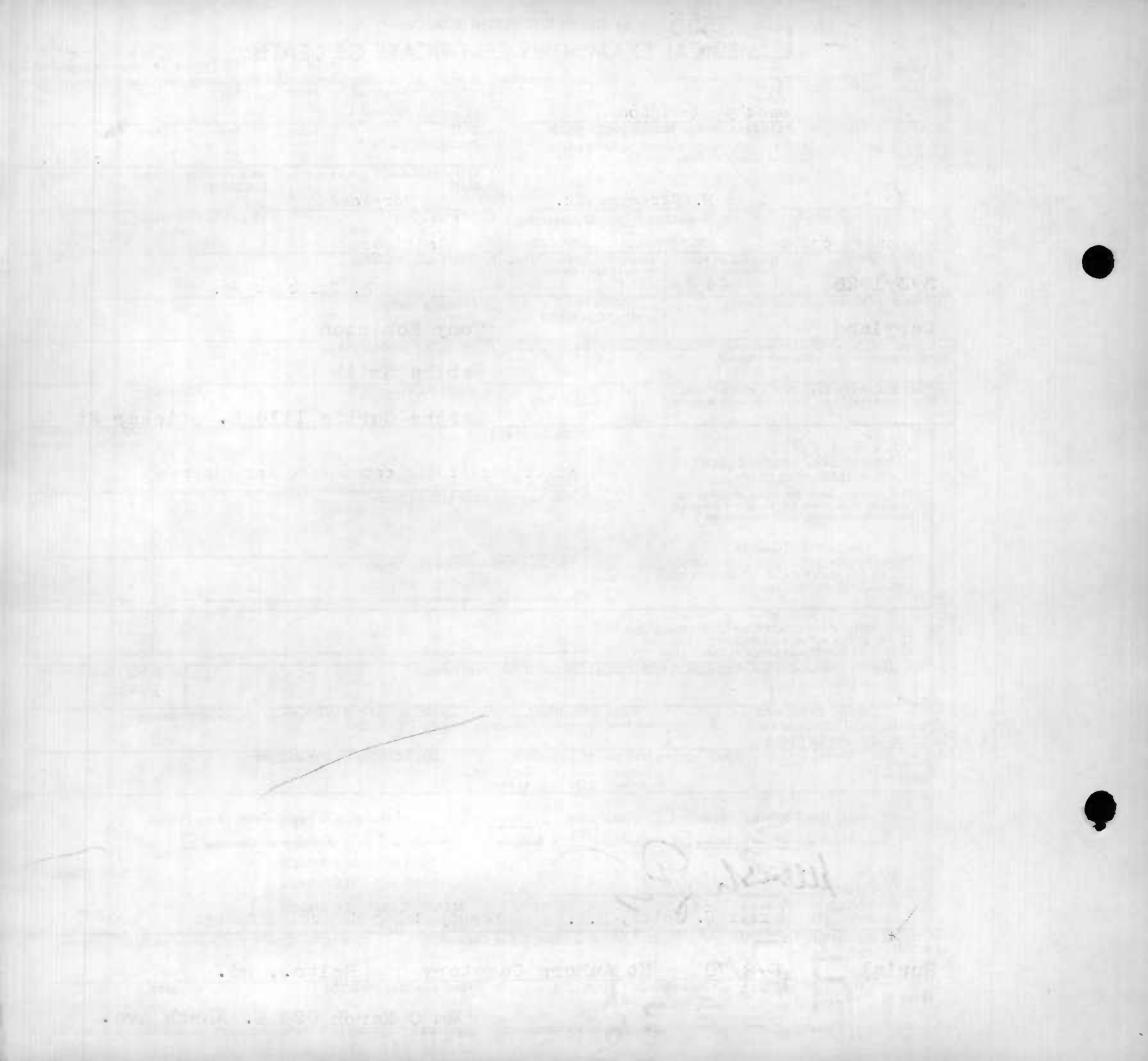
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5554</u>	
W-300 70 5554		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ETHEL Waddy</u>		2. DATE AND HOUR OF DEATH <u>5/28/70 6:25 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Pleasant Manor Convalescent Center</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>18 N. Bruce Street 1901</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31/07</u>	9. AGE (In years lost birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SMITH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CATHRYN ROBERSON 18 N. BRUCE</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>70 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Cerebrovascular Accident-Thrombotic 6 yrs</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 19 <u>69</u> to <u>4/6/28</u> 19 <u>70</u> . that (I) <u>last</u> saw the deceased alive on <u>5/21</u> 19 <u>70</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>Harvey S. Feuerman</u>		23B. DATE SIGNED <u>5/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Harvey S. Feuerman</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/1/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem</u>	
24D. LOCATION <u>BALTO. MD.</u>		24E. ADDRESS <u>1401 Reston Road; Pikesville, MD</u>		24F. CITY, TOWN, or county (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>W. M. C. MARCH</u>	
25D. ADDRESS <u>928 E NORTH</u>					



BIRTH NO. <u>R-152</u> <u>70</u> <u>5555</u> BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. <u>70</u> <u>5555</u>			
1. NAME OF DECEASED (Type or Print) <u>Dorothy Robinson</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>5</u> <u>30</u> <u>70</u> <u>6:15 a. m.</u>							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1116 N. Stricker St.</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>5</u> <u>30</u> <u>70</u> <u>6:15 a. m.</u>							
6. SEX <u>female</u> 7. RACE <u>colored</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1901</u>							
9. DATE OF BIRTH <u>3/3/1926</u> 10. AGE (In years last birthday) <u>44</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				E. STREET AND NUMBER <u>1116 N. Stricker St.</u>							
13. FATHER'S NAME <u>Tony Robinson</u>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>148. KIND OF BUSINESS OR INDUSTRY</u>							
15. MOTHER'S MAIDEN NAME <u>Martha Smith</u>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)							
17. SOCIAL SECURITY NO. <u>412.4</u>				18. INFORMANT <u>Martha Curtis</u> ADDRESS <u>1116 N. Sticker St</u>							
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
20A. DATE OF OPERATION <u>2</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>yes</u>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)							
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)							
22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>6/2/70</u>							
24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>							
25C. FUNERAL DIRECTOR <u>Wm C March</u>				ADDRESS <u>928 E. North Ave.</u>							





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-000		70 5556		70 5556	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LEE S. SHAW		May 30, 1970 8:19 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND		1001	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Bethlehem Steel		N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN SHAW		MARY CAGIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		714-09-6414		Bessie W. Shaw 1011 N. Central Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Liver Failure	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Alcoholism	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Sepsis	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 16 1970 to May 30 1970 that (I) (we) lost saw the deceased alive on May 30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard Bensinger MD				May 30, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RICHARD BENNINGER MD				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/3/70		Mt Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 2 1970		Robert E. Jaben, R.D.		W. A. March 928 E. North Ave.	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-550 70 5557		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5557	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALLEN M. (NEMAN) NEWMAN</b>		2. DATE AND HOUR OF DEATH <b>5-29-70 1 15 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1501</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITAL</b> 4940 EASTERN AVENUE #21224		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1508 BAKER STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-31</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ROBERT NEWMAN</b>		14. MOTHER'S MAIDEN NAME <b>Betty HOWELL</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-26-4079</b>		17. INFORMANT RECORDS: B C H 4940 EASTERN AVENUE ADDRESS	
18. <b>446.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PROB. INTRACEREBRAL HEMORRHAGE</b> (B) <b>HEPATITIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>RENAL TRANSPLANT REJECTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~30min</b> <b>~4 days</b> <b>~1 day</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>GOODPASTER'S SYNDROME</b>		<b>~20yr</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-27</b> 19 <b>70</b> to <b>5-29</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>5-29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard K Maza M.D.</b>		23B. DATE SIGNED <b>5-29-70</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD K MAZA M.D.</b>	
23D. ADDRESS <b>B C H 4940 EASTERN AVENUE #21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/2/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
24D. LOCATION <b>BALTO. MD.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR <b>WM. C. MARCH</b>	
25D. ADDRESS <b>928 E. NORTH AVE</b>					

BRANDMERE CITY

STREET

INTERSECTION

HEATERS

TRANSPORT SYSTEM

SYNDICATE

Richard K. King

2-26

2-26

2-26

X

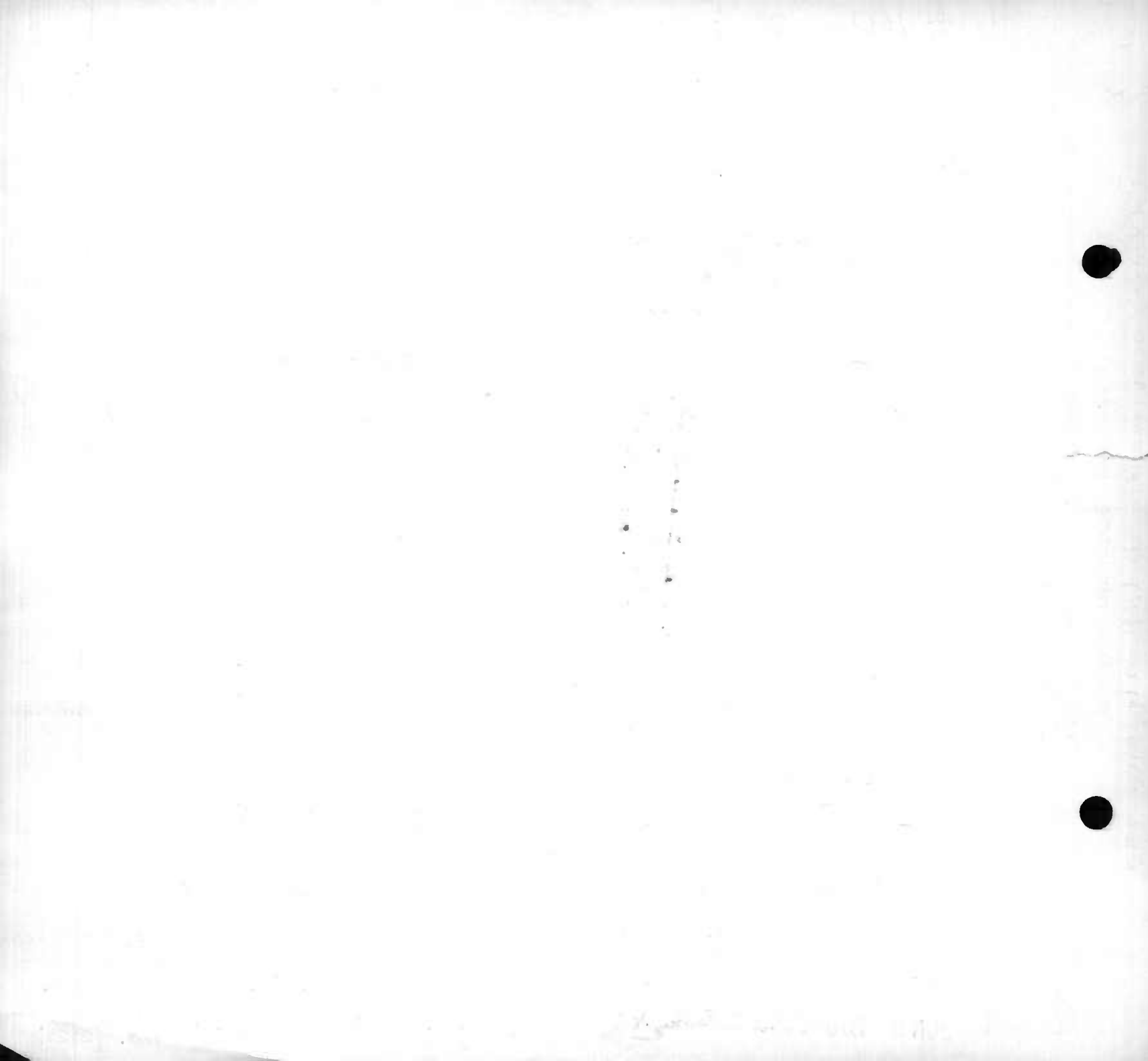
2-26-2

RELEASED TO BRIDE MEDICAL EXAMINER.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-160 70 5558		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		REG. NO. 70 5558	
1. NAME OF DECEASED (Type or Print) MRS. WILLIAM C. J. HOOPER IRE. M.		2. DATE AND HOUR OF DEATH MAY 1 1970 3-50 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 33RD CALVERT STS. BALTO. MD. 21218		A. STATE MD B. COUNTY BALTIMORE 1203	
5. SEX FEMALE		6. RACE WHITE (AMERICAN)	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-11-77	
9. AGE (In years last birthday) 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TYLER		14. MOTHER'S MAIDEN NAME ELIZABETH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT (Nurse on duty U.M.H. 11 pm to 7 AM duty) G. CARROLL HOOPER (SAME)		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROSIS	
19A. DATE OF OPERATION 0 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? F	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NOTIFIED		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME 331 E 29th ST. BALTO MD		21D. TIME (Month) (Day) (Year) (Hour) (Approx.) 5/25/70	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? SKIPPED FROM FOOTSTEPS	
22. I certify that (1) (this hospital) attended the deceased from 5/25/70 to 6/1/70 and that (2) (we) last saw the deceased alive on 5/31/70 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ashwin Mehla M.D. DEGREE	
23B. DATE SIGNED JUNE 1st 70		23C. PHYSICIAN'S NAME (Type) ASHWIN MEHTA M.D. DEGREE	
23D. ADDRESS UNION MEMORIAL HOSP. BALTO MD 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 6-3-70		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery Balto. Co.	
24D. LOCATION (City, town, or county) (State) Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620 70 5559		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5559	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>MARGARET E. Gross</u>				2. DATE AND HOUR OF DEATH <u>5/29/70</u> <u>6:25 p.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>				A. STATE <u>BALTO.</u> B. COUNTY <u>BALTO. City</u> <u>5300</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>620 RICESTER AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/97</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emory L. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Carter</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-28-6598</u>		17. INFORMANT <u>John J. Gross</u>		ADDRESS <u>(SAME)</u>	
18. <u>250.9 I</u> CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/29/70</u> 19 <u>70</u> to <u>5/29/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/29/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>G. V. Ribeiro</u>				23B. DATE SIGNED <u>5/29/70</u>		23C. PHYSICIAN'S NAME (Type) <u>G. V. Ribeiro</u>	
23D. ADDRESS <u>Union Memorial Hospital</u>		23E. DEGREE <u>MD</u>		23F. DEGREE <u>MD</u>		23G. DEGREE <u>MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Fairmount</u>		24D. LOCATION (City, town, or county) (State) <u>Libertytown, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Rd Balto., Md. 21212</u>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-000 70 5560		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 5560	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE W. SOOY</b>		2. DATE AND HOUR OF DEATH <b>5/28/70 11 40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2714</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>4 UNION MEMORIAL HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>4 UPLAND ROAD</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/00</b>	9. AGE (in years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DIRECTOR-FOOD &amp; DRUG AD. U.S. GOV'T.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>GEORGE W. SOOY</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH KRAUSE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>317-34-8545</b>		17. INFORMANT <b>MRS. MARY SOOY</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pneumonitis</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular disease and Cerebral Arteriosclerosis</b>		CAUSE OF DEATH <b>Uremia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/24</b> 19 <b>70</b> to <b>5/28</b> 19 <b>70</b> . that (I) (we) last saw the deceased alive on <b>5/28</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anne L. Leddy M.D.</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Anne L. Leddy MB</b>	
23D. ADDRESS <b>Union Memorial Hospital</b>		23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Crementation</b>		24B. DATE <b>6-1-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Md.</b>		24F. LOCATION (City, town, or county) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

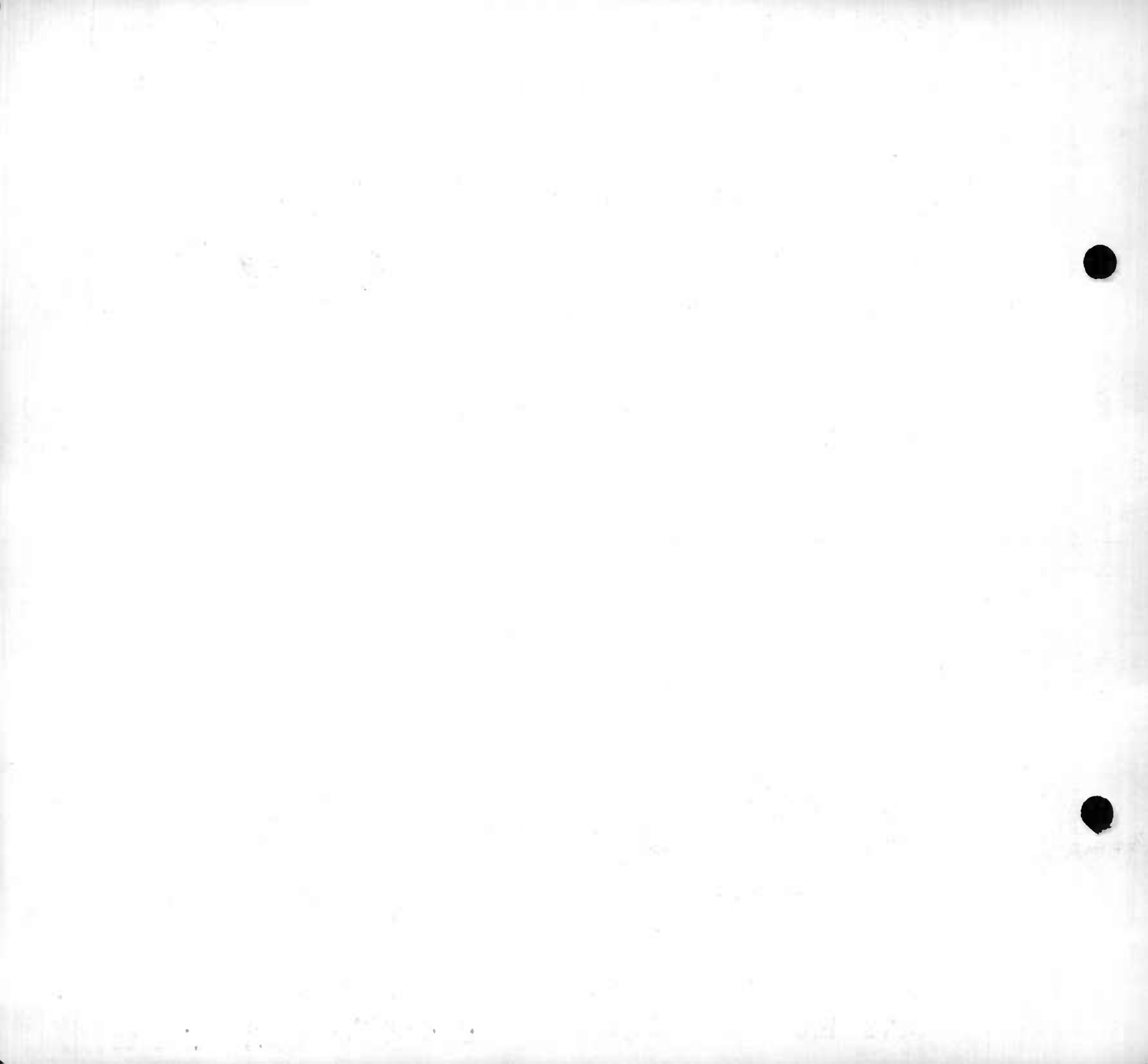
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5561</span>	
S-162 70 5561 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">OTHA THOMAS SPRIGGS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/30/70</span> <span style="float: right;">315 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <span style="font-size: 1.2em;">44 UNION MEMORIAL HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2710</span>			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">44 UNION MEMORIAL HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <span style="font-size: 1.2em;">4754 ALHAMBRA AVE.</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/21/93</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">76</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MAINT. ENGINEER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">BOUCHER COLLEGE</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">JOHN WESLEY SPRIGGS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARTHA NEWMAN</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES WWI</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218-10-2976</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS SADIE SPRIGGS</span>	
ADDRESS <span style="font-size: 1.2em;">4754 ALHAMBRA AVE</span>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Acute Pulmonary Edema</span>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from <span style="font-size: 1.2em;">5/29</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">5/30</span> 19 <span style="font-size: 1.2em;">70</span> that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/30</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Anne L. Leddy M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/30/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Anne L. Leddy</span>		23D. ADDRESS <span style="font-size: 1.2em;">Union Memorial Hospital Staff</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6-3-70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Balto. Nat'l. Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore</span>		24E. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Md.</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 2 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Hays</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">H.W. Jenkins</span>	
25D. ADDRESS <span style="font-size: 1.2em;">Sons Co. 4905 York Rd.</span>		25E. ADDRESS <span style="font-size: 1.2em;">Baltimore, Md. 21212</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5562</span>	
C-452 70 5562		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MISS. GRACE W. COLLINS		MAY 28 TH, 1970 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  CHURCH HOME and HOSPITAL			A. STATE MARYLAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN BALTIMORE		
			E. STREET AND NUMBER 1512 PENTRIDGE RD.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/86	9. AGE (in years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A. (AMERICA)			13. FATHER'S NAME CHARLES H. COLLINS		
14. MOTHER'S MAIDEN NAME ISABELLE HILTZ			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 218.54.3722			17. INFORMANT MISS ANNA B. COLLINS (SAME)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Basal pneumonia, Cholecystitis, 8 days			CAUSE OF DEATH Arteriosclerotic heart disease with congestive failure Over 8 days  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Advanced Central Arteriosclerosis 10 yrs  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19A. DATE OF OPERATION 5/21/1970			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis, Cholelithiasis		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 5/20/1970 to 5/28/1970 that (1) (we) lost saw the deceased alive on 5/20/1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ahmad F. Azam</i> MD			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/28/70
23C. PHYSICIAN'S NAME (Type) AHMAD F. AZAM MD			23D. ADDRESS Church Home & Hospital Balto., Md 21231		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/70	24C. NAME of CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR H. W. S. Jenkins & Sons Co. 4905 York Rd Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5563</u>	
C-515 70 5563		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Laura E. Campen</u>			2. DATE AND HOUR OF DEATH <u>May 29, 1970</u> <u>8 40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1202</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2916 St. Paul St.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1883</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry C. Campen</u>			14. MOTHER'S MAIDEN NAME <u>Louise Myers</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Miss Theresa A. Campen</u> ADDRESS <u>Same</u>		
18. <u>412.3 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Dis.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10-15 YRS</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 29 1970</u> to <u>MAY 29 1970</u> that (I) (we) last saw the deceased alive on <u>MAY 29 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert W. Garis, M.D.</u>			SUBSTITUTE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>MAY 31, 1970</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. Robert W. Garis</u>			23D. ADDRESS <u>Ambassador Apts. #308 BALTIMORE, MD. 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-2-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Garis, Jr.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>	

8 #0 B

10-12 YRS is (Heart) substituted

MAY 29 TO

MAY 29 TO MAY 29

MAY 31, 1970

BALTIMORE, MD.  
5118

#308

SUBSTITUTE  
X

Robert W. Jones, MD.

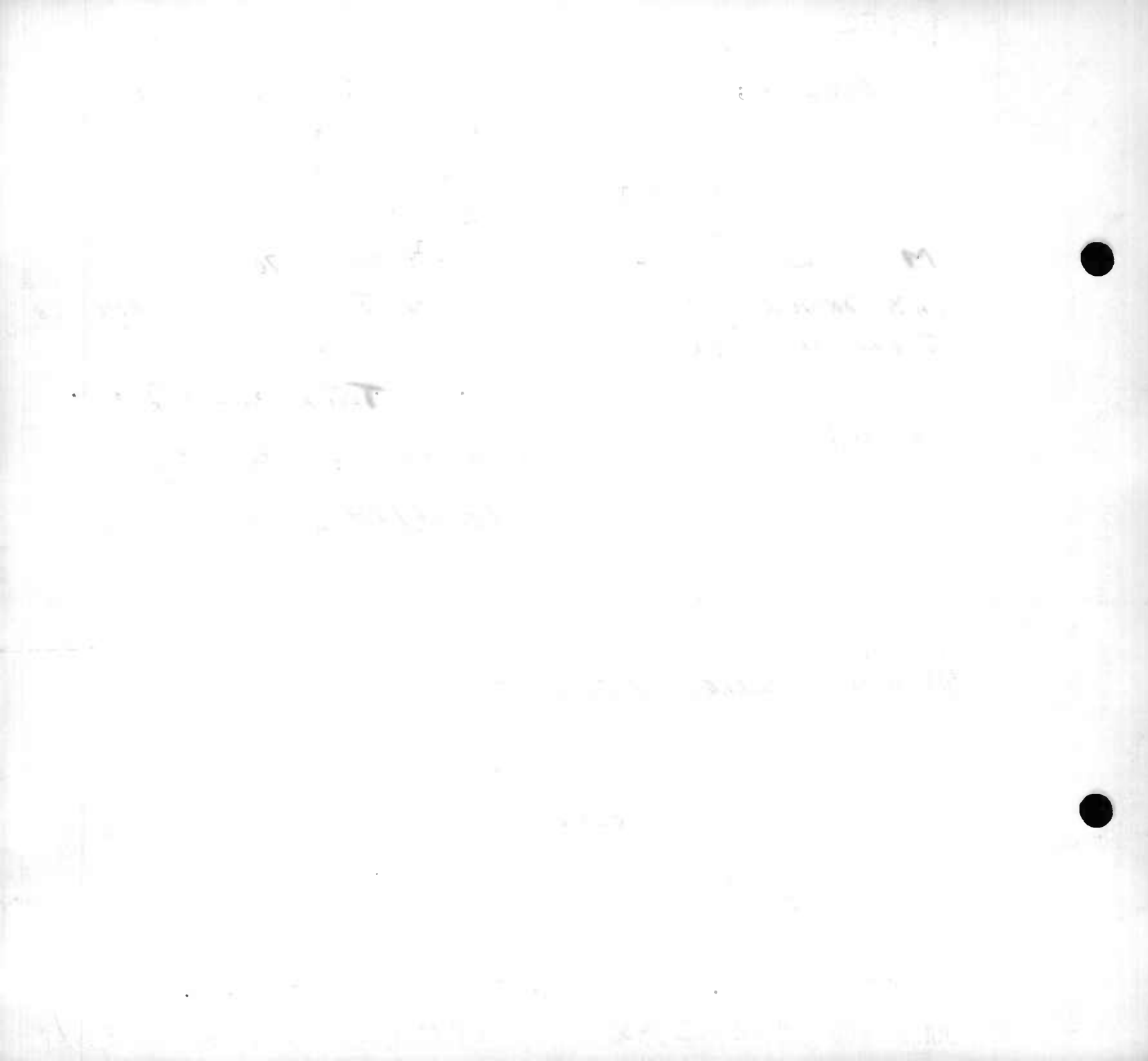
Burial 6-2-70 Greenmount Cemetery Baltimore, Md.  
H.W. Jenkins Sons Co. 4000 York Rd



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

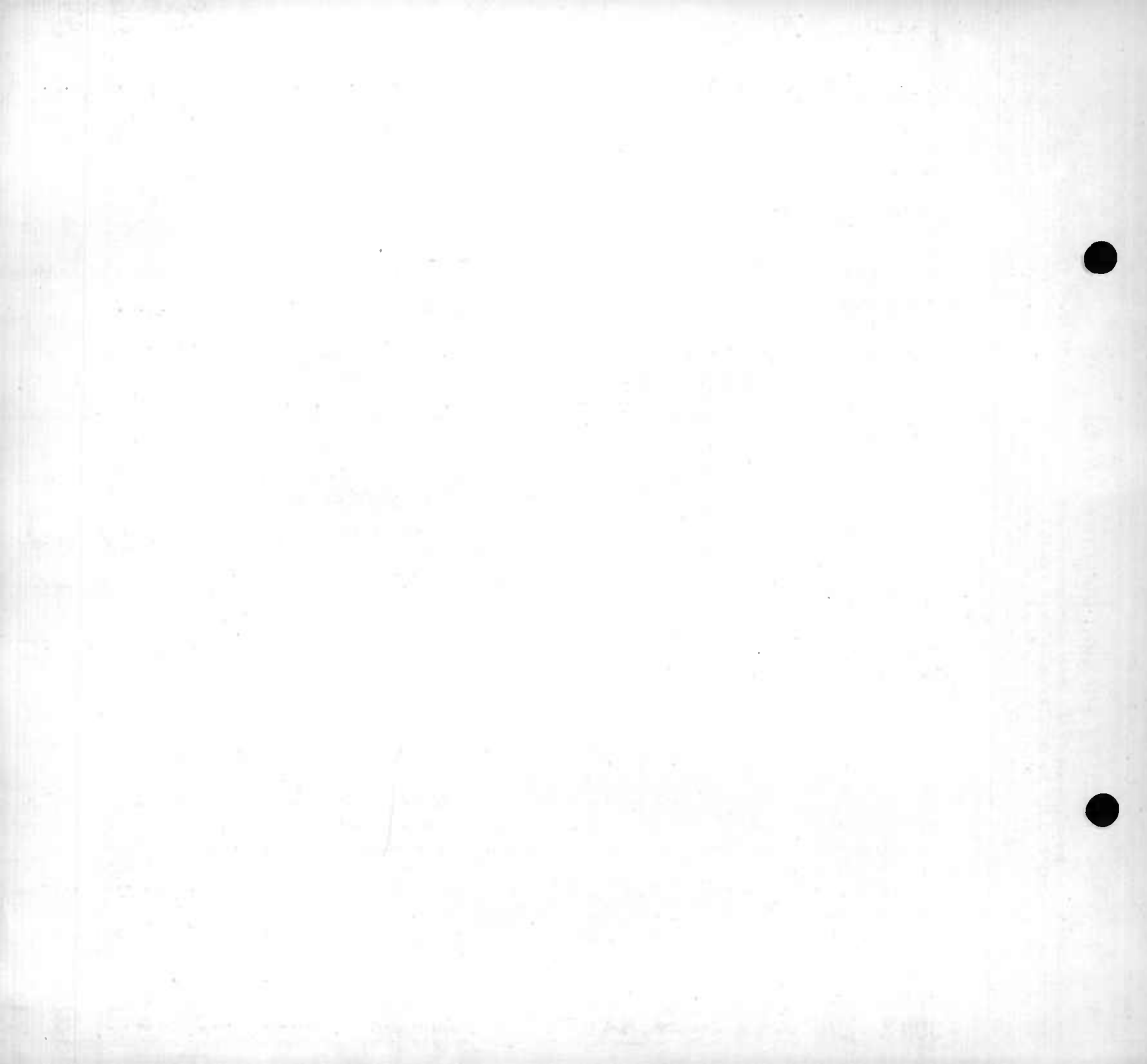
Baltimore City Health Department				REG. NO. 70 5564	
BIRTH NO. 8-652		70 5564		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BRINSTER; MR. JOSEPH. L.</b>			2. DATE AND HOUR OF DEATH <b>5/29/70-5:30 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>M. D.</b> B. COUNTY <b>2</b>		
5. SEX <b>M</b>			6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1-5-00</b>			9. AGE (In years last birthday) <b>70</b>		10. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAB DRIVER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>N. J.</b>
12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>			13. FATHER'S NAME <b>JOSEPH BRINSTER</b>		
14. MOTHER'S MAIDEN NAME <b>SOPHIA ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W I</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. John J. Brinster, Clarksville, Md.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Subphrenic abscess, leaking duodenostomy</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cholelithiasis, stricture common duct</b>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>3-24-70</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholelithiasis, stricture common duct</b>		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 5-29-70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carlos A. Le Plaza</b>			23B. DATE SIGNED <b>5/29/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>CARLOS A. LEA PLAZA</b>			23D. ADDRESS <b>5518 SARRIL RD BALTO 21206</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/2/70.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>	
25C. FUNERAL DIRECTOR <b>W. J. Ruck, Inc.</b>		25D. ADDRESS <b>5305 HANFORD RD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 70 5565				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5565	
1. NAME OF DECEASED (Type or Print) <b>Price, Margaret</b>				2. DATE AND HOUR OF DEATH <b>May 29, 1970 7:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Bolton Hill Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/7/83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Unknown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Driver</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Lucille Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-28-0575</b>		17. INFORMANT <b>Mr. Robert A. Wittman</b>		ADDRESS <b>(Same)</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C.A. T. infection metastases</b> (B) <b>osteomyelitis, generalized</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>arteriovenous heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/22</b> 19 <b>66</b> to <b>5/29</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>al Martin</b>				23B. DATE SIGNED <b>5/29/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MARTIN MD</b>				23D. ADDRESS <b>2 E Real St Balto Md 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/1/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md.</b>	



A-516

70 5566

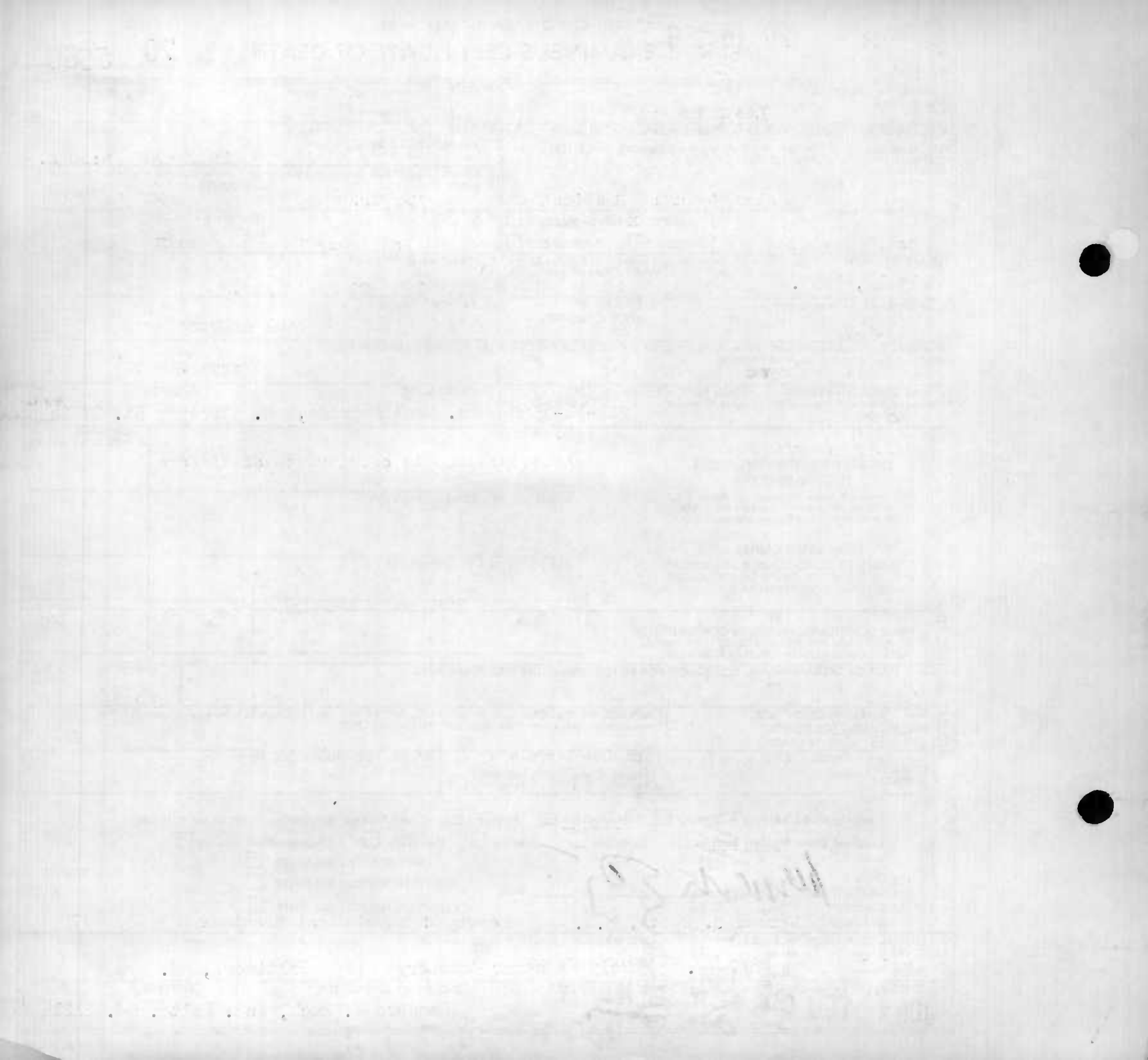
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5566

BIRTH NO.

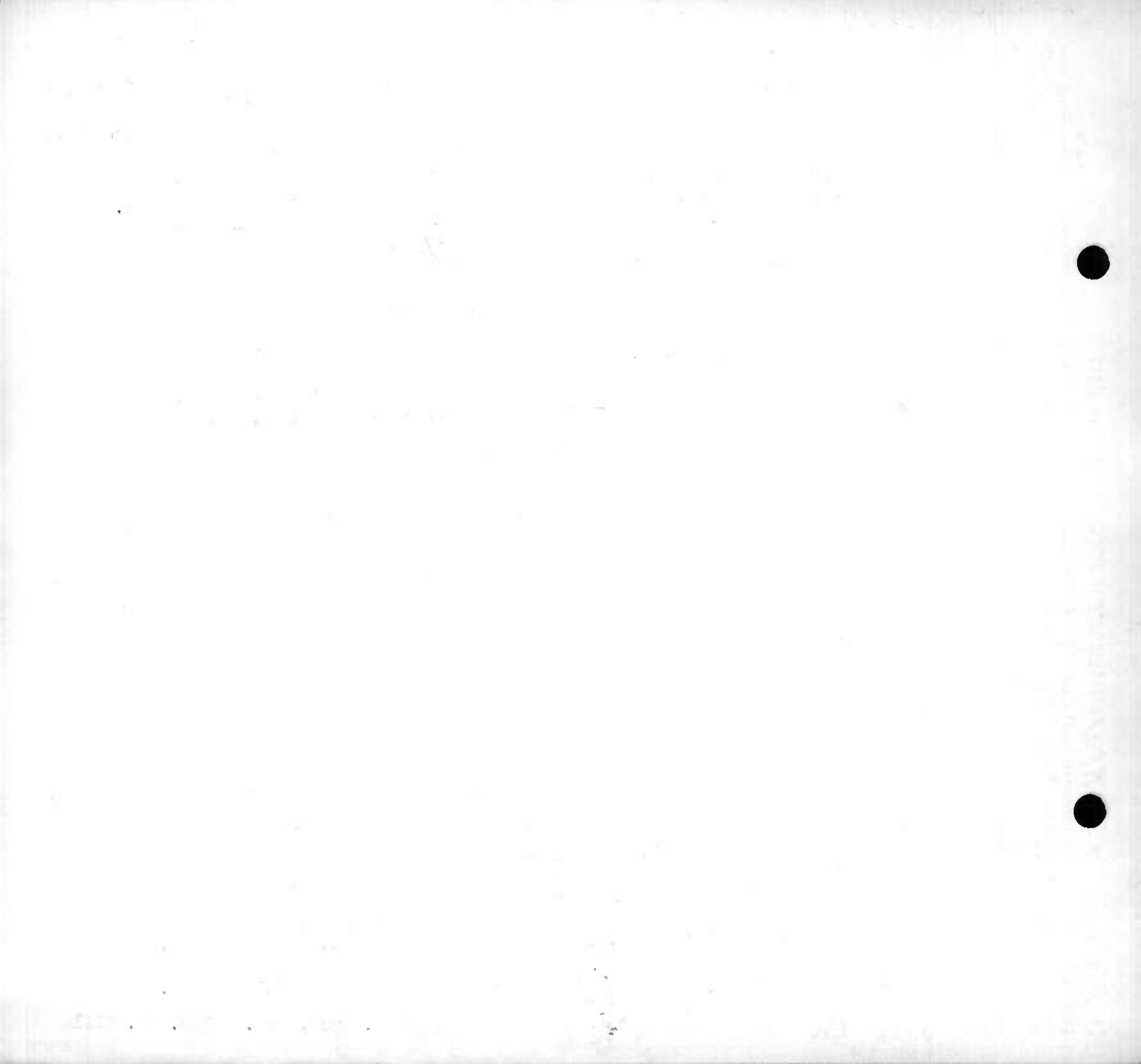
1. NAME OF DECEASED (Type or Print) <b>Leo Ambrose</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>5 29 70 6:50 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>5 29 70 6:50 a.m.</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2757</b>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>July 17, 1892.</b>		10. AGE (In years last birthday) <b>77</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF <b>USA</b>	E. STREET AND NUMBER <b>2911 Glendale Ave.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <b>Mary ?</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-14-6560</b>	18. INFORMANT ADDRESS <b>Mr. Paul Ambrose, 9 N. Streeper St. 21224</b>
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/30/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/2/70.</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">0-540</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">70 5567</span>	
1. NAME OF DECEASED (Type or Print) <i>Mary O'Neill</i>			2. DATE AND HOUR OF DEATH <i>May 30 1970 10:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1111 Brentwood Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/20/87</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Martin McGreevy</i>			14. MOTHER'S MAIDEN NAME <i>Annie Dufficy</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>211-01-9390</i>		17. INFORMANT <i>4940 Eastern Ave. BCH Records: Baltimore, Md. 21224</i>
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiorespiratory Arrest.</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Edema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Acute</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASCVD</i>			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i>		<i>48 hrs.</i>
(C) _____			_____		<i>Years.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <i>May 29</i> 19 <i>70</i> to <i>May 30</i> 19 <i>70</i> that (X) (we) lost saw the deceased alive on <i>May 30</i> 19 <i>70</i> and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francisco Tejada M.D.</i>				23B. DATE SIGNED <i>5-30-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Francisco Tejada M.D.</i>				23D. ADDRESS <i>Baltimore, City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/2/70.</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5568</u>	
70 5568		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JANE R. GUERCIO</u>		2. DATE AND HOUR OF DEATH <u>MAY 31, 1970</u> <u>5:35 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO STATE HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2738</u>	
		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1127 Hollen Road</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1919</u>
9. AGE (In years lost birthday) <u>51 y.o.</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry A. Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Gertrude Hall</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-05-4917</u>		17. INFORMANT <u>Mr. Samuel J. Guercio</u>	
18. <u>348.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>OCT 20 1969</u> to <u>MAY 31 1970</u> that (I) (we) last saw the deceased alive on <u>MAY 31 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Kiao-Siong Tan, M.D.</u>		23B. DATE SIGNED <u>MAY 31, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>KIAO-SIONG TAN, M.D.</u>		23D. ADDRESS <u>Montebello State Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/4/70.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Rack, Inc. Balto. Md. 21214</u>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 5569</span>	
<p><span style="font-size: 1.5em;">S-363</span> <span style="font-size: 1.5em;">70 5569</span></p> <p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">CHARLES STEWART</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">XXXX 5-27-70</span> <span style="float: right;">11:25 AM</span></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)</p> <p style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p><b>A. STATE</b> <span style="font-size: 1.2em;">MARYLAND</span> <span style="float: right;">603</span></p> <p><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2203 LAMLEY ST.</span></p>			
<p><b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span></p> <p><b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9 4 05</span></p> <p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">64</span></p> <p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span></p> <p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>	
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">SAMUEL Stewart</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">STELLA KNOX</span></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span></p>		<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-01-5119</span></p>		<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Anna Rowland 2203 Lamley St.</span></p>	
<p><b>18. CAUSE OF DEATH</b></p>					
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">UREMIA</span></span></p> <p><span style="font-size: 1.2em;">(B) CHRONIC PYELONEPHRITIS DUE TO, OR AS A CONSEQUENCE OF:</span></p> <p><span style="font-size: 1.2em;">(C) _____</span></p>					
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p> <p><span style="font-size: 1.5em;">ISCHEMIC BRAIN DISEASE</span></p>					
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY? (Yes or No)</b> <span style="font-size: 1.2em;">YES</span></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 29, 1970</span> to <span style="font-size: 1.2em;">May 27, 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 27, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Richard Bensinger MD</span></p>				<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">May 27, 1970</span></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.5em;">RICHARD BENNINGER MD</span></p>				<p><b>23D. ADDRESS</b> <span style="font-size: 1.5em;">JOHNS HOPKINS HOSPITAL</span></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial Cremation</span></p>		<p><b>24B. DATE</b> <span style="font-size: 1.2em;">5/29/70</span></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Green Mount Cemetery</span></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 2 1970</span></p>			
<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span></p>		<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">John A. Moran, Inc. 3000 E. Balto. St.</span></p>			

ALBERTA

CHRONIC PNEUMONITIS

IT IS NOT A PAIN DISEASE

WAS 5' 10" TO 6' 0" TALL

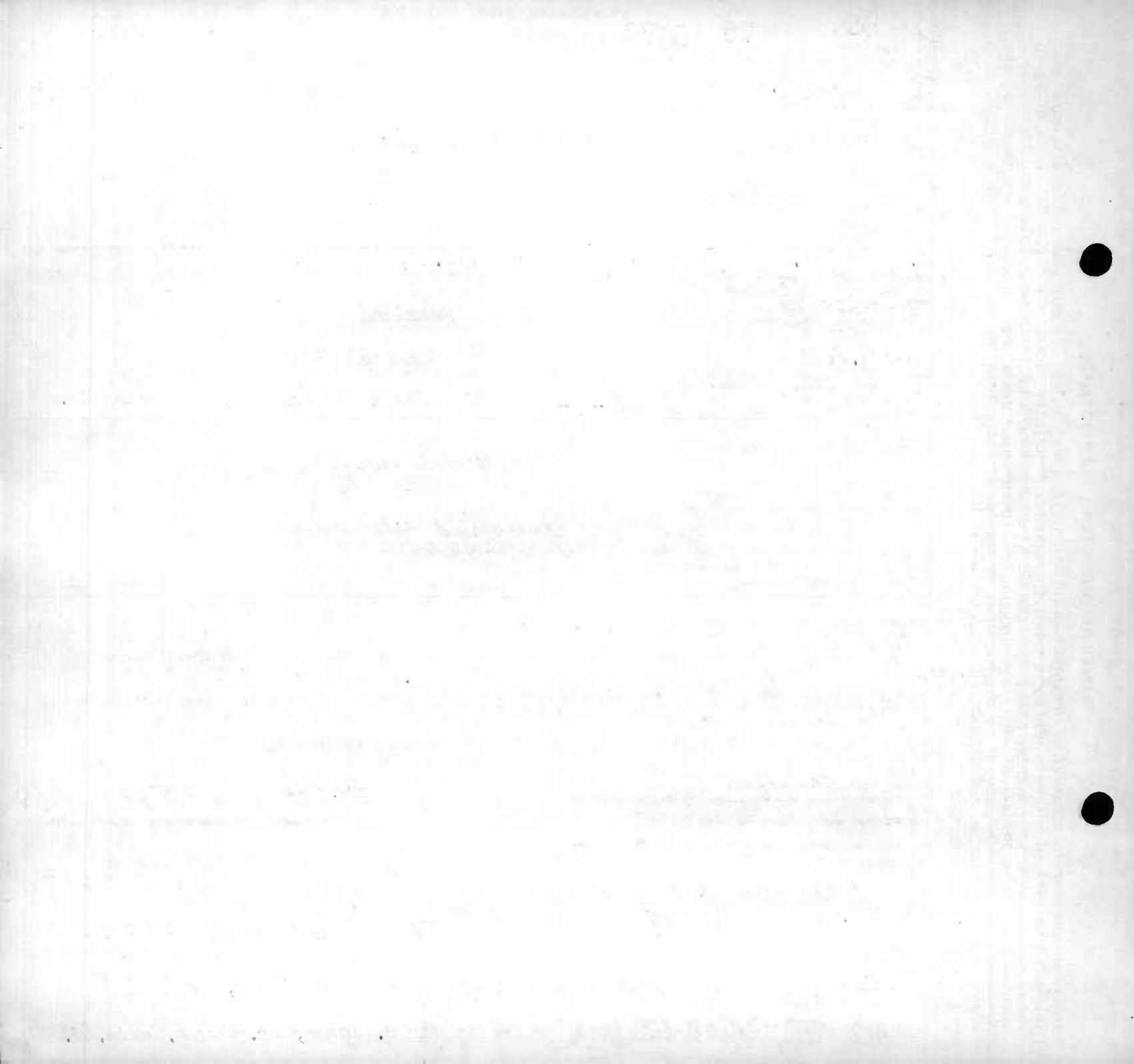
RICHARD BENNETT MD  
JAMES HOBBS MD  
X  
MAY 25 1900

JUN 2 1900

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>70 5570</u>	
BIRTH NO. <u>B-600</u>				70 5570 <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Mary F. Barry</u>				2. DATE AND HOUR OF DEATH <u>May 26, 1970</u> <u>11:20 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Long Green Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>175 Dumbarton Road</u>			
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1885</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John J. Fell</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Nigl</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>274-05-3548</u>		17. INFORMANT ADDRESS <u>Miss Margaret Barry 175 Dumbarton Rd.</u>		
18. <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular insufficiency</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5</u> years			
MEDICAL CERTIFICATION							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) <u>this office</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>1962</u> to <u>5/21</u> 19 <u>70</u> , that <u>we</u> last saw the deceased alive on <u>5/21</u> 19 <u>70</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (We) (did not) view the body after death.							
23A. SIGNATURE <u>Ramon Roig MD</u>				23B. DATE SIGNED <u>5-26-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Ramon Roig MD</u>				23D. ADDRESS <u>701 St Paul 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/29/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talle, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John A. O'Pran, Inc. 3000 E. Balto. St.</u>			



R-500 70 5571 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 70 5571

BIRTH NO.

1. NAME OF DECEASED  
 (Type or Print)

Charles J. Rooney, Jr.

2. DATE OF DEATH Known ☒ Estimated ☐  
 Month Day Year Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General

3. DATE PRONOUNCED DEAD Month Day Year Hour  
 5 30 70 9:35 p. m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
 A. STATE Maryland B. COUNTY 2402

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Feb. 22, 1921

10. AGE (In years last birthday)

49

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U S A

E. STREET AND NUMBER

1415 Covington St.

13. FATHER'S NAME

Charles J. Rooney Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cutter

14B. KIND OF BUSINESS OR INDUSTRY

Canvas

15. MOTHER'S MAIDEN NAME

Margaret Klemmick

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes # 2

17. SOCIAL SECURITY NO.

18. INFORMANT

Mrs. Margaret E. Rooney 1415 Covington St.

ADDRESS

19.

412.41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
 NO

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

5/31/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6.2.70

24C. NAME OF CEMETERY or CREMATORY

Dulaney Valley Gardens

24D. LOCATION (City, town, or county) (State)

Cockeysville, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1970

25B. NAME OF REGISTRAR

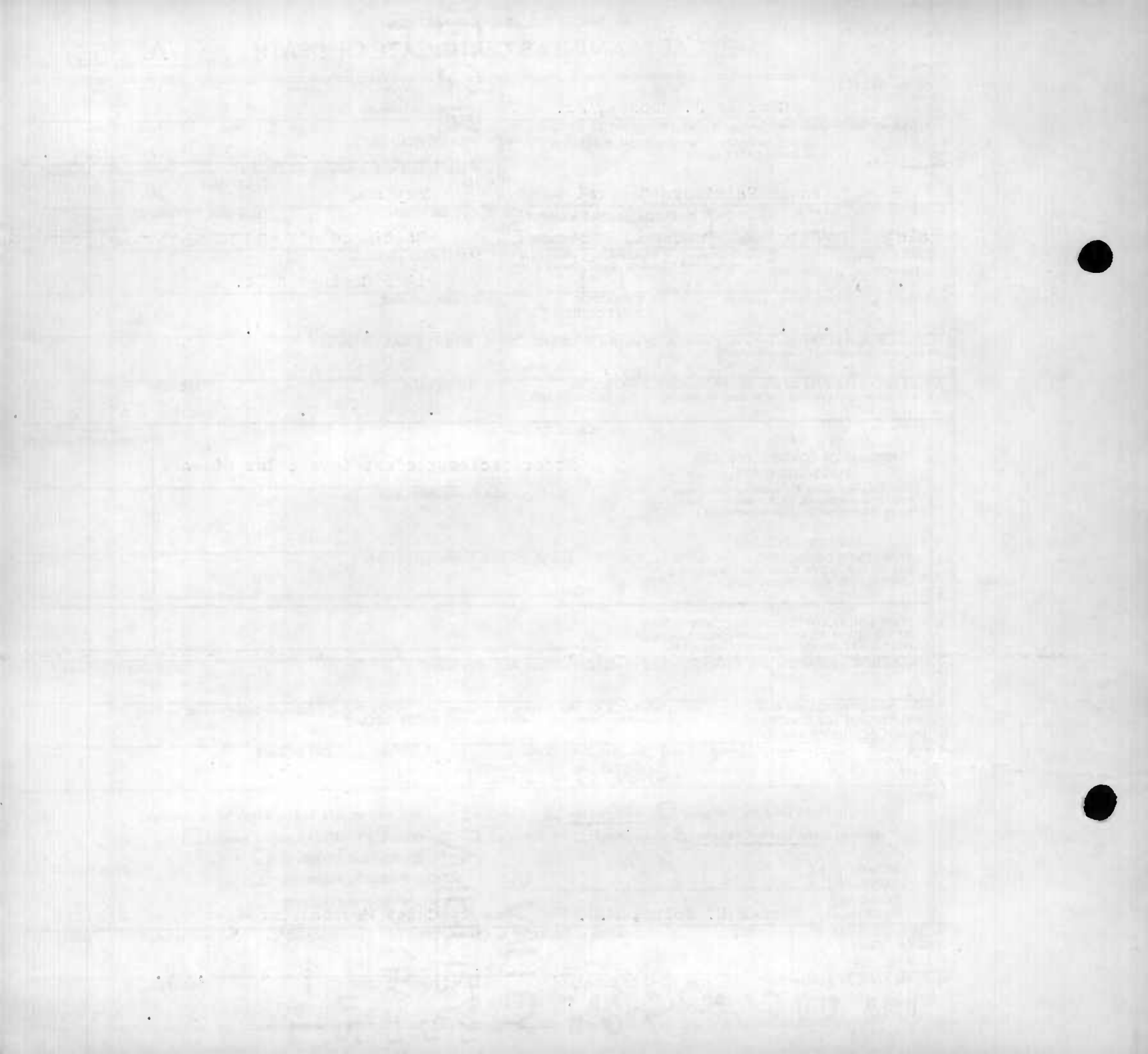
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
M-325 70 5572		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MIEDZINSKI - ANNA J</b>		2. DATE AND HOUR OF DEATH <b>9.10 P.M. MAY - 30 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL, 22 South GREENE, BALTIMORE MD - 21201</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1009 BEECHDALE AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-23-18</b>	9. AGE (In years last birthday) <b>52</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John W. Erzbicki</b>			
14. MOTHER'S MAIDEN NAME <b>Josephine Kazmierski</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. —		17. INFORMANT <b>Peter U. Miedzinski, 1009 Beechdale Ave</b>			
18. <b>394.0 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>CARDIAC ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <b>Pneumatic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Post op, mitral &amp; tricuspid valve replacement.</b>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>4-16-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>valve replacement</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <b>8 P.M. 5-30</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rostam Fardin M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ROSTAM FARDIN M.D.</b>		23D. ADDRESS <b>University Hospital.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-3-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. F...</b>		25C. FUNERAL DIRECTOR <b>...</b>			
25D. ADDRESS <b>1211 Chesapeake Ave</b>					



LIBRARY  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 70 5573		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5573	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HENRY E. BARANOWSKI</b>		2. DATE AND HOUR OF DEATH <b>MAY 30, 1970 17<sup>30</sup> A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital BALTIMORE, MD 21205</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>701</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>511 N. LINWOOD AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1908</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Park Board Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>JOHN BARANOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIE A. Harchut</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Helen Baranowski 511 N. Linwood Ave</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Cerebral Hypoxic Episode</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDIAL INFARCTION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>12 days</b> <b>4 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bilateral Pneumonia</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>MAY 18</b> 19 <b>70</b> to <b>MAY 30</b> 19 <b>70</b> and that (2) (we) lost saw the deceased alive on <b>MAY 30</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen P. Achuff</b>		23B. DATE SIGNED <b>May 30, 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN ACHUFF</b>		23D. ADDRESS <b>M.D. THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/2/70</b>	24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. J...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran, Inc. 3000 E. Baltimore St.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-315		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5574	
BIRTH NO. 70 5574		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>THOMAS E. STEVENSON</b>			2. DATE AND HOUR OF DEATH <b>May 31, 1970 10:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME HOSPITAL 35</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>USA</b> <b>2605</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>82 E. Rappahannock St (24)</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/8/17</b>	9. AGE (In years last birthday) <b>52</b>
				If Under 1 Yr. Months	If Under 1 Yr. Days
				If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Chauffeur</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland, USA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Stevenson</b>			14. MOTHER'S MAIDEN NAME <b>Alice XXXXXXX Canbourne</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>215-05-3603</b>		
			17. INFORMANT <b>Mary Wainia (daughter)</b>		
			ADDRESS <b>726 Under St, Baltimore, MD. (26)</b>		
18. <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory arrest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few min.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>maximal pulmonary edema &amp; restrictive lung disease</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>unknown</b>		
			(C) <b>congestive heart failure</b> <b>1 month?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>upper gastrointestinal bleeding</b>			<b>few hrs.?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>18</b> (this hospital) attended the deceased from <b>May 31</b> 19 <b>70</b> to <b>May 31</b> 19 <b>70</b> that <b>18</b> (we) last saw the deceased alive on <b>May 31</b> 19 <b>70</b> and that in <b>18</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>18</b> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rolando A. Mendez, M.D.</b>			23B. DATE SIGNED <b>5/31/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>ROLANDO A. MENDOZA, M.D.</b>			23D. ADDRESS <b>100 N. Broadway St, Baltimore, MD. 21231</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/4/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>John J. Moran, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3000 E. Baltimore St</b>	

The following is a list of the names of the persons who have been  
 named in the report of the committee on the subject of the  
 proposed amendment to the constitution of the State of New York.  
 The names are given in the order in which they were named.  
 The names of the persons who have been named in the report of the  
 committee on the subject of the proposed amendment to the constitution  
 of the State of New York are given in the order in which they were  
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 the committee on the subject of the proposed amendment to the constitution  
 of the State of New York are given in the order in which they were  
 named.

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

BIRTH NO.

<b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">CHARLES M. DIEHL</span>		<b>2. DATE OF DEATH</b> Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 27, 1970	
<b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		<b>3. DATE PRONOUNCED DEAD</b> Month Day Year May 27, 1970 12:07 P.M.	
<b>6. SEX</b> Male		<b>7. RACE</b> White	
<b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>5. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO	
<b>9. DATE OF BIRTH</b> 7/14/98		<b>10. AGE</b> (in years last birthday) 60-71	
<b>11. BIRTHPLACE</b> (State or foreign country) MD		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>14A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) ?		<b>14B. KIND OF BUSINESS OR INDUSTRY</b>	
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO		<b>17. SOCIAL SECURITY NO.</b> 214-20-3258	
<b>18. INFORMANT</b> ELIA DIEHL		<b>ADDRESS</b> 252 N. MARLYN	
<b>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> Diabetes mellitus		<b>20A. DATE OF OPERATION</b> 2	
<b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>21. AUTOPSY? (Yes or No)</b> Yes	
<b>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>		<b>22D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)	
<b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>22F. HOW DID INJURY OCCUR?</b>	
<b>23.</b> I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: May 28, 1970			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) BURIAL		<b>24B. DATE</b> 6/1/70	
<b>24C. NAME OF CEMETERY or CREMATORY</b> PARKWOOD		<b>24D. LOCATION</b> (City, town, or county) (State) BALTO. MD.	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> JUN 2 1970		<b>25B. NAME OF REGISTRAR</b> J.G. CONNELLY	
<b>25C. FUNERAL DIRECTOR</b> J.G. CONNELLY SONS		<b>ADDRESS</b> 300 MALE	

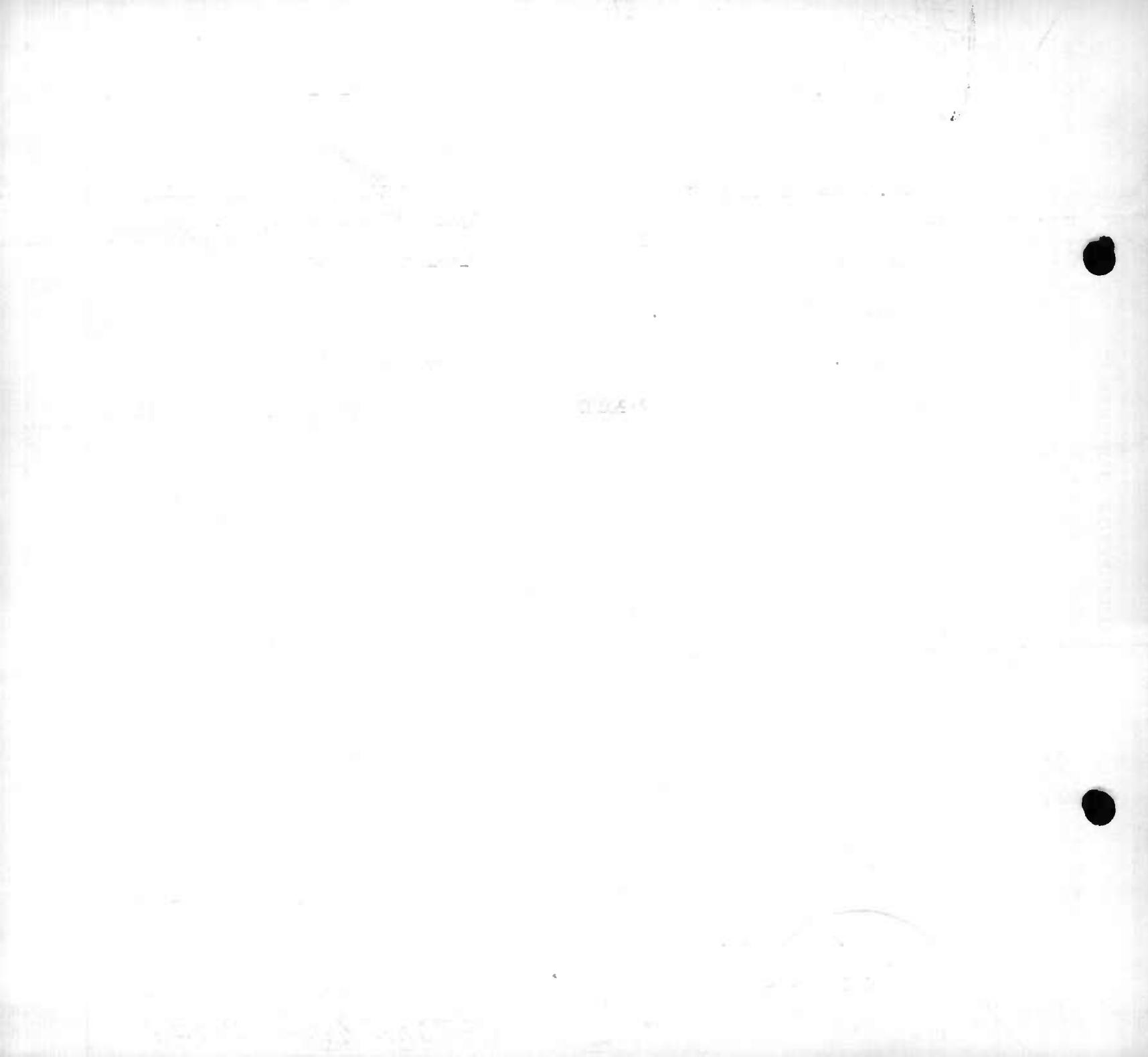




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

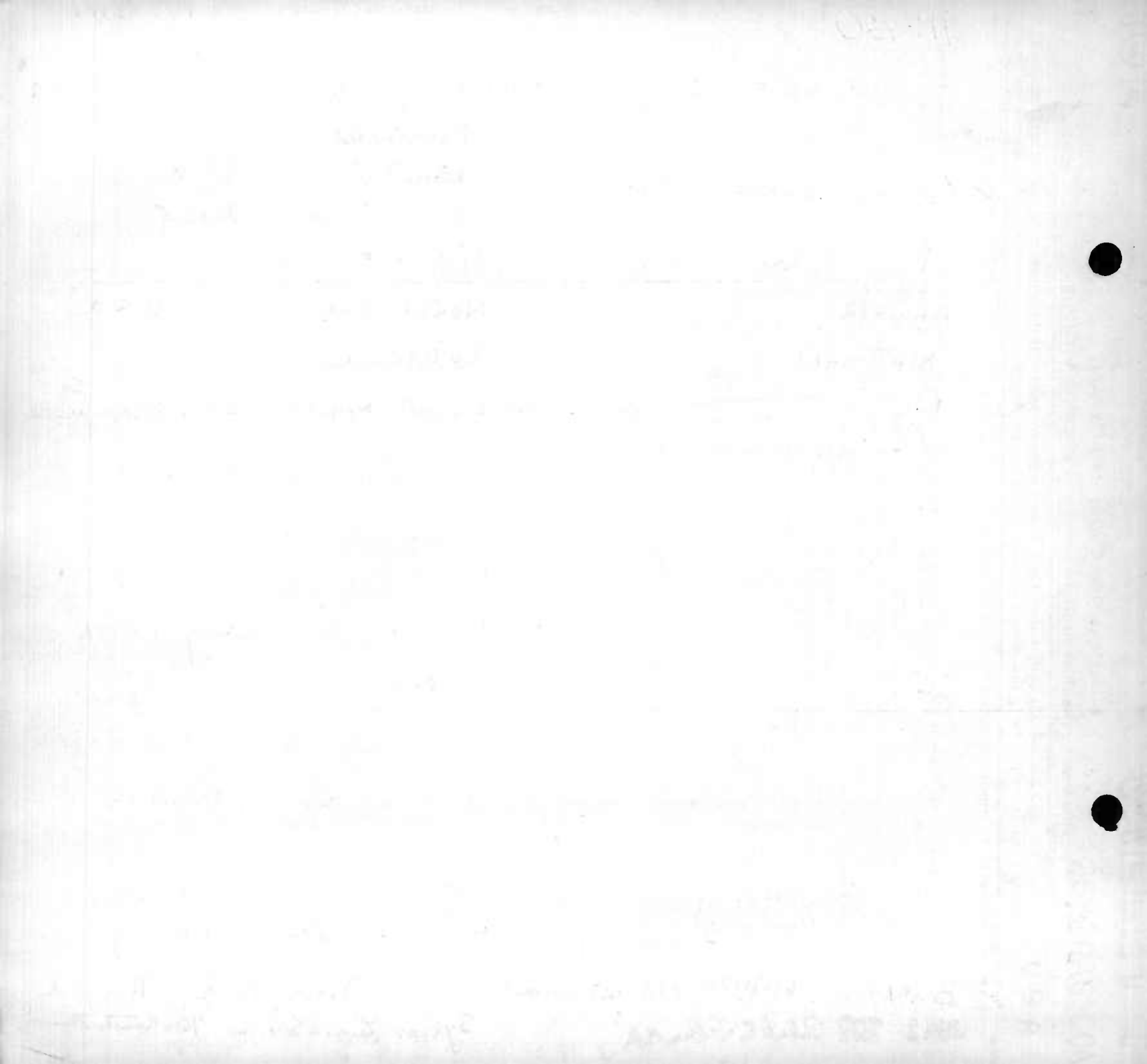
7-600				70 5576		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5576	
1. NAME OF DECEASED (Type or Print) <b>JOHN L. FREY</b>				2. DATE AND HOUR OF DEATH <b>5-29-70 4:20 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2551</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1023 ROCKHILL AVE.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-05</b>		9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Electric</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John W. Frey</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Collins</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-05 5764</b>		17. INFORMANT <b>Mrs Elizabeth Frey-1023 Rockhill Ave</b>				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Dehydration, due to vomiting, diarrhea, Cirrhosis of the liver, Emphysema, d. Peptic ulcer.</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>6-2-1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>A. Shams, M.D.</b>				23B. DATE SIGNED <b>5-29-70</b>		23C. PHYSICIAN'S NAME (Type) <b>A. SHAMS M.D.</b>			
23D. ADDRESS <b>ST. AGNES HOSPITAL</b>				23E. NAME OF REGISTRAR					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-2-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Ave Balto-Md</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>21228</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

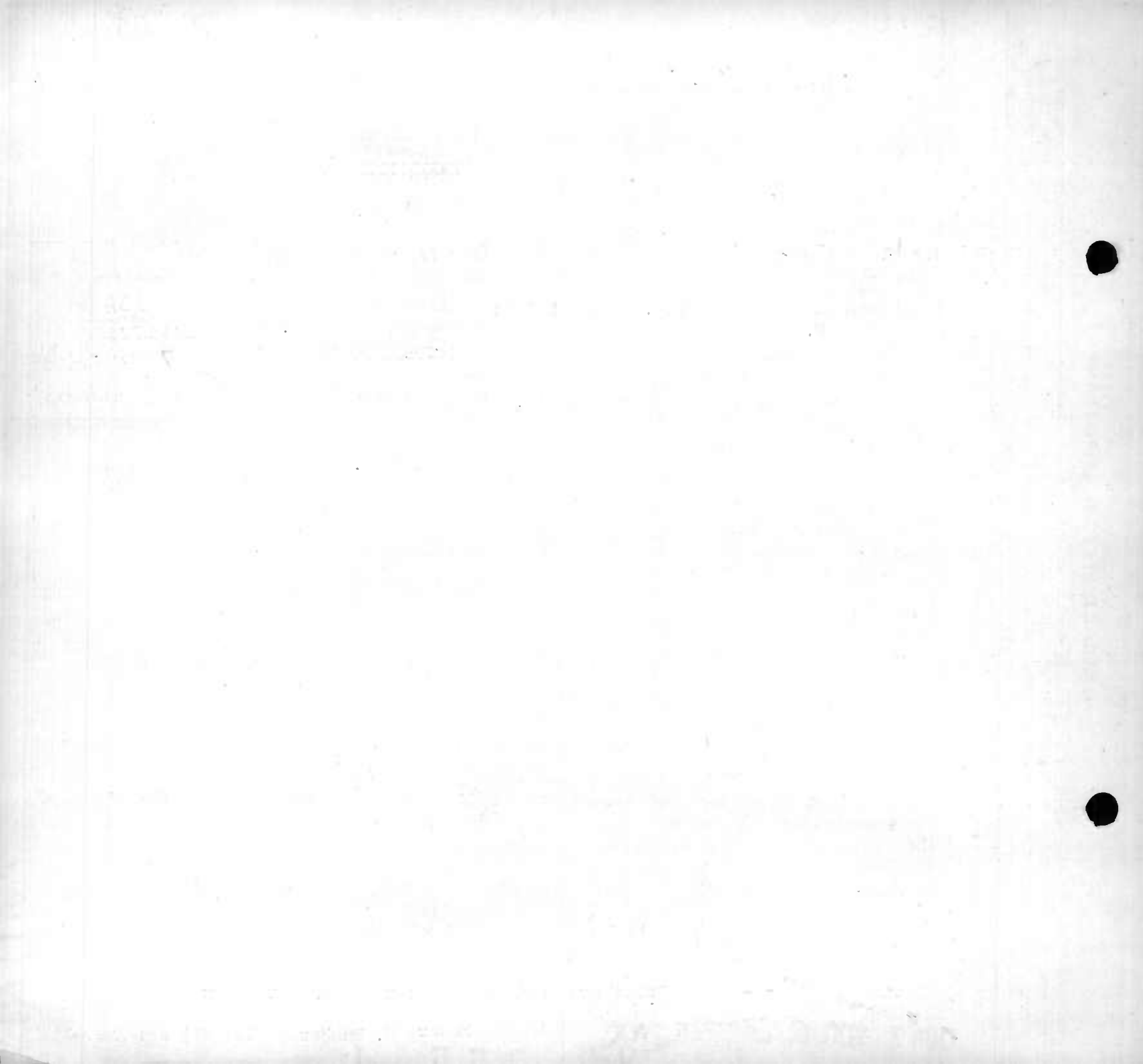
Baltimore City Health Department				REG. NO. 70 5577			
BIRTH NO. M-420 70 5577				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MINNIE ORLEANS MALIS				2. DATE AND HOUR OF DEATH MAY 29, 1970 2a M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7001 SURREY DRIVE				A. STATE MARYLAND B. COUNTY BALTO			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 7001 SURREY DRIVE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/3/1896	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME NATHAN			14. MOTHER'S MAIDEN NAME Rebecca				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 109-06-1926		17. INFORMANT ADDRESS Sg 3711 KINGWOOD		
18. 183.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Generalized Carcinomatosis 6 months				
ANTECEDENT CAUSES			(B) Carcinoma of uterus 6 months				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) H A S T I D 4 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Embolus to right popliteal artery 1 week				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/5 1965 to 5/29/70 19 that (I) (we) last saw the deceased alive on 5/25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE I S. Zinberg				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/29/70	
23C. PHYSICIAN'S NAME (Type) I S. Zinberg				23D. ADDRESS 4000 W. Northern Pkway			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/1/1970		24C. NAME OF CEMETERY or CREMATORY old Mt Carmel		24D. LOCATION (City, town, or county) (State) New York New York	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR R. E. ...		25C. FUNERAL DIRECTOR Sylvan Lewis & Son, Inc 9610 Reisterstown Rd			



# FUNERAL DIRECTOR: IMPORTANT

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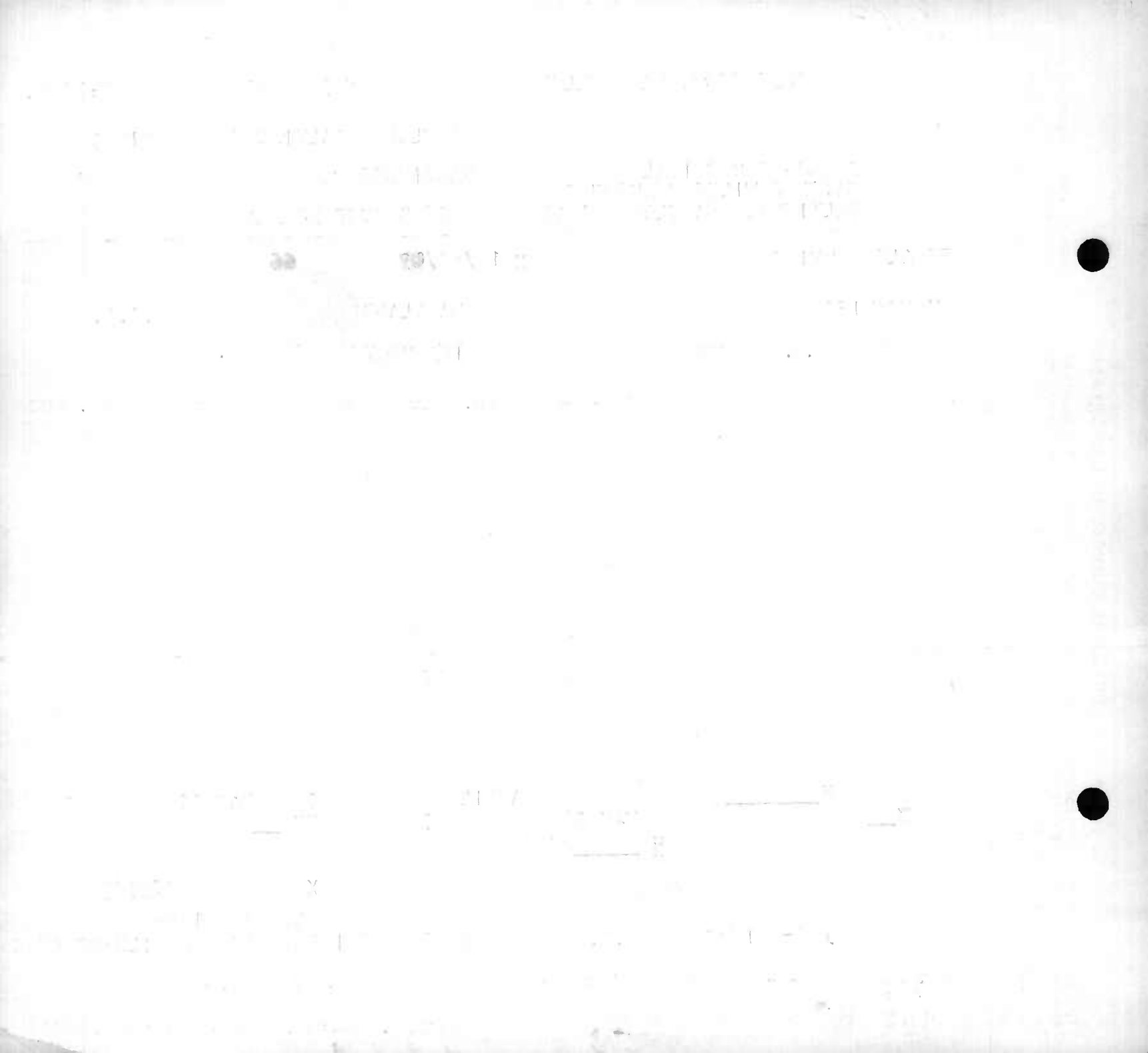
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5578</span>	
<b>W-230</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">70 5578</span> <span style="font-size: 1.5em;">William Charles West</span>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">May 30, 1970</span> <span style="float: right;">8:00A M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <b>5. SEX</b> <span style="font-size: 1.2em;">male</span> <b>6. RACE</b> <span style="font-size: 1.2em;">Cauc</span> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Dec 17, 1929</span> <b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">40</span> <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Policeman</span> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Balto. County Police</span> <b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Indiana</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span> <b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">F. Walter West</span> <b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">FRIEDA STEWART</span> <span style="font-size: 1.2em;">Jeanette West</span> <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes 1950 - 1954</span> <b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">218 26 4400</span> <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Hospital chart - ? wife (same address)</span>					
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>19. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">yes</span> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <span style="font-size: 1.2em;">yes</span> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>		<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">July 31 1968</span> to <span style="font-size: 1.2em;">May 30 1970</span> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 30 1970</span> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. <b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Samuel P. Ward, M.D.</span> <b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">May 30, 1970</span> <b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Samuel P. Ward M.D.</span> <b>23D. ADDRESS</b> <span style="font-size: 1.2em;">USPHS Hospital</span> <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span> <b>24B. DATE</b> <span style="font-size: 1.2em;">6-3-1970</span> <b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Baltimore National Cemetery</span> <b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span> <b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 2 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Howard H. Hubbard</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">4107 Wilkens Ave. 21229</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>K-163</b></span> <span><b>70 5579</b></span> </div>		<b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 70 5579</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print)		<b>2. DATE AND HOUR OF DEATH</b> MAY 31 1970 3:15 A.M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE 21227-5306 <b>C. CITY OR TOWN</b> BALTIMORE ARBUTUS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> 1256 GREYSTONE ROAD			
<b>5. SEX</b> FEMALE	<b>6. RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> 10/09/09	<b>9. AGE</b> (In years last birthday) 60	<b>10. UNDER 1 Yr.</b> <input type="checkbox"/> <b>11. UNDER 24 Hrs.</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) HOUSEWIFE		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) MARYLAND	
<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> JOHN B.E. MARTIN			
<b>14. MOTHER'S MAIDEN NAME</b> IDA E. HUNTER		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No			
<b>16. SOCIAL SECURITY NO.</b> 219-16-3652		<b>17. INFORMANT ADDRESS</b> Mr. Harry Robertson, 1256 Greystone Rd. 21227			
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 20 19 70 to MAY 31 19 70 that (I) (we) last saw the deceased alive on MAY 31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tse-Shiung Wu		23B. DATE SIGNED 05/31/70		23C. PHYSICIAN'S NAME (Type) TSE-SHIUNG WU, M.D.	
23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL, CATON & WILKENS AVES		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6-3-1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21227	

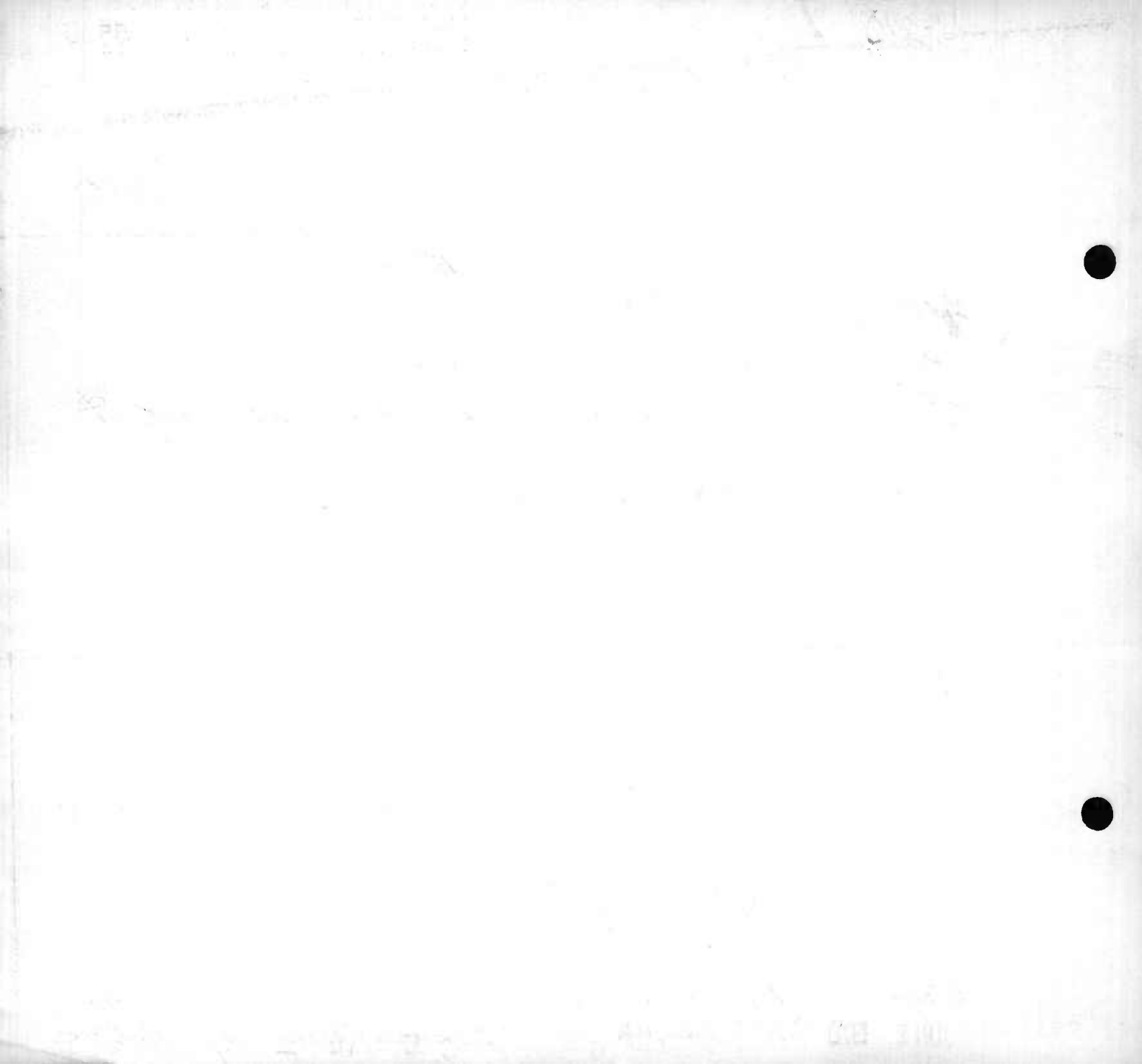




# FUNERAL DIRECTOR: IMPORTANT

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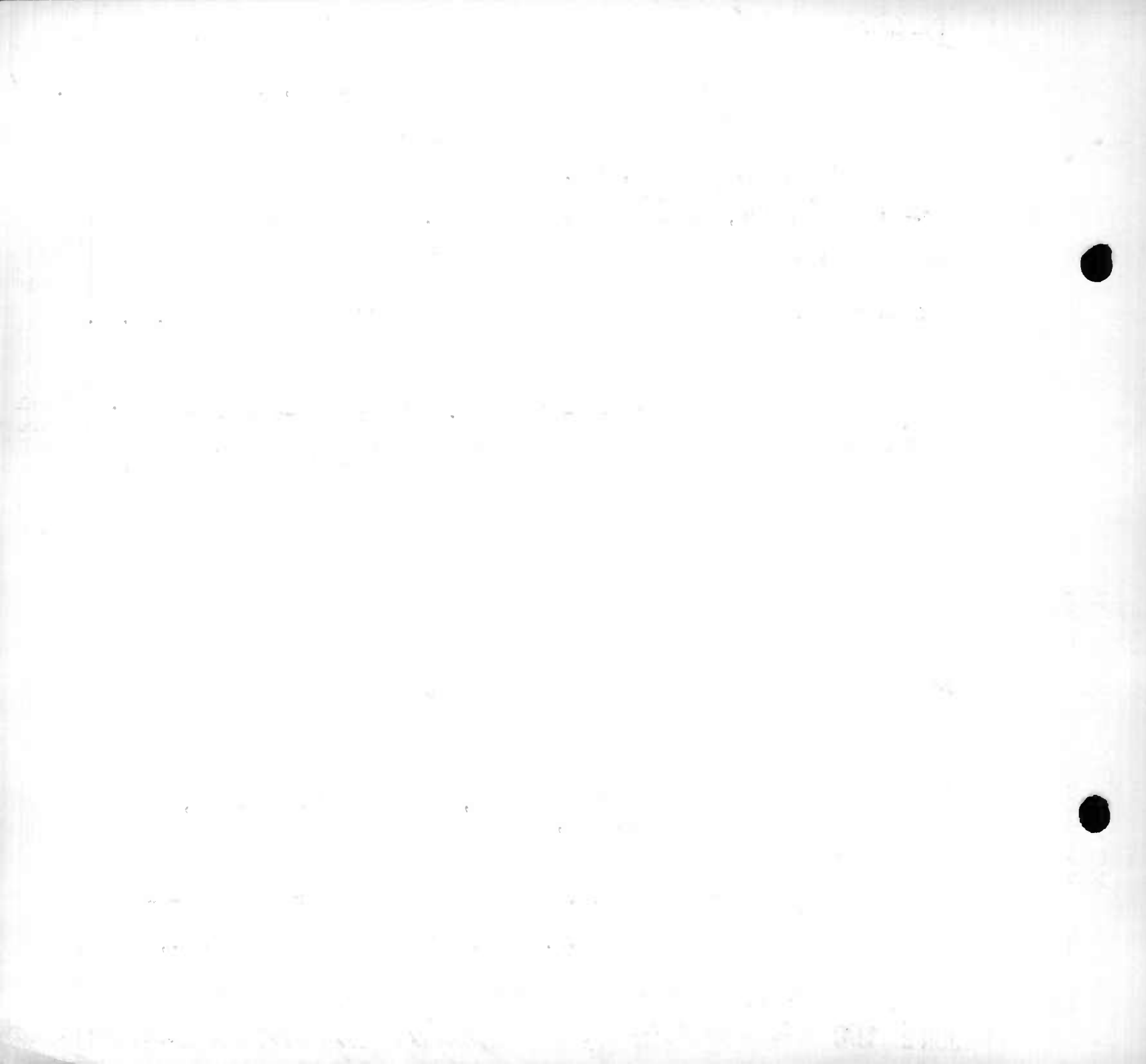
BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		3580	
BIRTH NO. <b>C-240</b>		REG. NO. <b>31-22-21</b>	
1. NAME OF DECEASED (Type or Print) <b>FRANKLIN RANDALL CASSELL</b>		2. DATE AND HOUR OF DEATH <b>5/30/70 1:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. HOSPITAL</b>		C. CITY OR TOWN <b>BALTO.</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>W</b>		E. STREET AND NUMBER <b>5603 St Mary St</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-22</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		9. AGE (in years last birthday) <b>47</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
13. FATHER'S NAME <b>William Cassell</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>HOLDA SHEETS</b>	
16. SOCIAL SECURITY NO. <b>226-70-0220</b>		17. INFORMANT <b>Violet R. Cassell</b>	
18. <b>4-10-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		(B) <b>sw. yrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>5/29</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/29 1970</b> to <b>5/30 1970</b> that (I) (we) last saw the deceased alive on <b>5/30 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Barry Schlossberg</b>		23B. DATE SIGNED <b>5-30-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Barry Schlossberg</b>		23D. ADDRESS <b>UNIV. HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-2-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard Strong</b>		ADDRESS <b>307 W. North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

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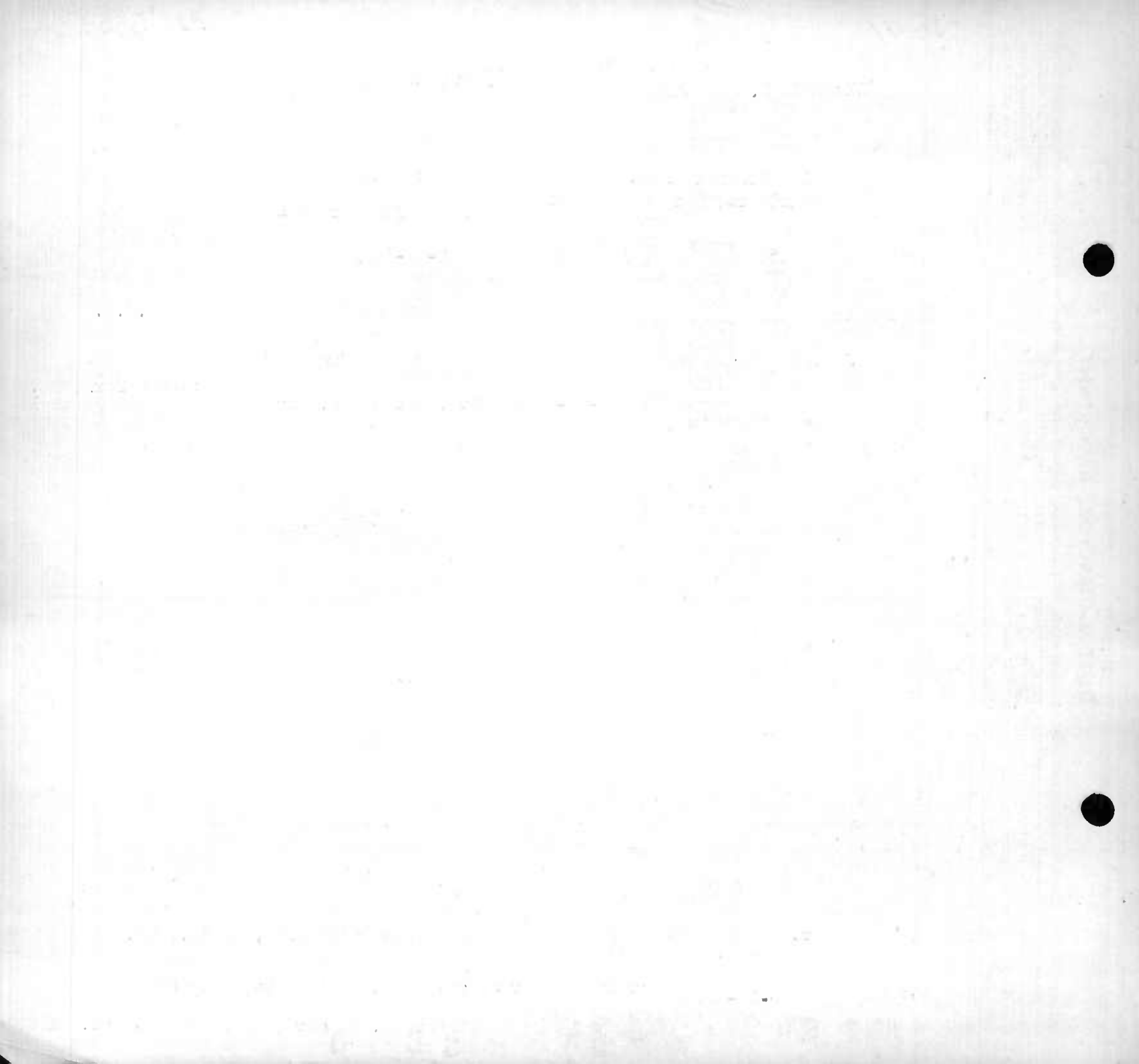
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5581</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">D-650</span>		<span style="font-size: 1.5em;">70 5581</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Roscoe Durham</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">June 1, 1970 6:00 a.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1205</span>		
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.5em;">39</span> <span style="font-size: 1.2em;">Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</span>			<b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>			<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Bethlehem Steel</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12/6/99</span>
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">70</span> If Under 1 Yr. Months:    Days:    If Under 24 Hrs. Hours:    Min.
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">152-05-5926A</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">North Carolina</span>
<b>17. INFORMANT</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">ASHD &amp; Ventricular FIBRILLATION</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Previous myocardial infarction</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">1 hr</span> <span style="font-size: 1.5em;">2-3 yrs</span>
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">May 16,</span> <span style="font-size: 1.2em;">19 70</span> <b>to</b> <span style="font-size: 1.2em;">June 1,</span> <span style="font-size: 1.2em;">19 70</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">June 1,</span> <span style="font-size: 1.2em;">19 70</span> <b>and that in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</span>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Elijah Sanchez M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6-1-70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">1514 Division Street Balto., Maryland</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b> <span style="font-size: 1.2em;">6/5/70</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">ARBUTUS CEM.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State)		<b>24E. DATE REC'D BY HEALTH DEPT.</b>		<b>24F. NAME OF REGISTRAR</b>	
<span style="font-size: 1.5em;">JUN 2 1970</span>		<span style="font-size: 1.2em;">Robert E. Hickey, R.D.</span>		<b>24G. FUNERAL DIRECTOR</b>	
<span style="font-size: 1.5em;">VS 150-REV. 1/1/68</span>		<span style="font-size: 1.5em;">E. E. Ellickson</span>		<span style="font-size: 1.2em;">1129 N. CAROLINE ST.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

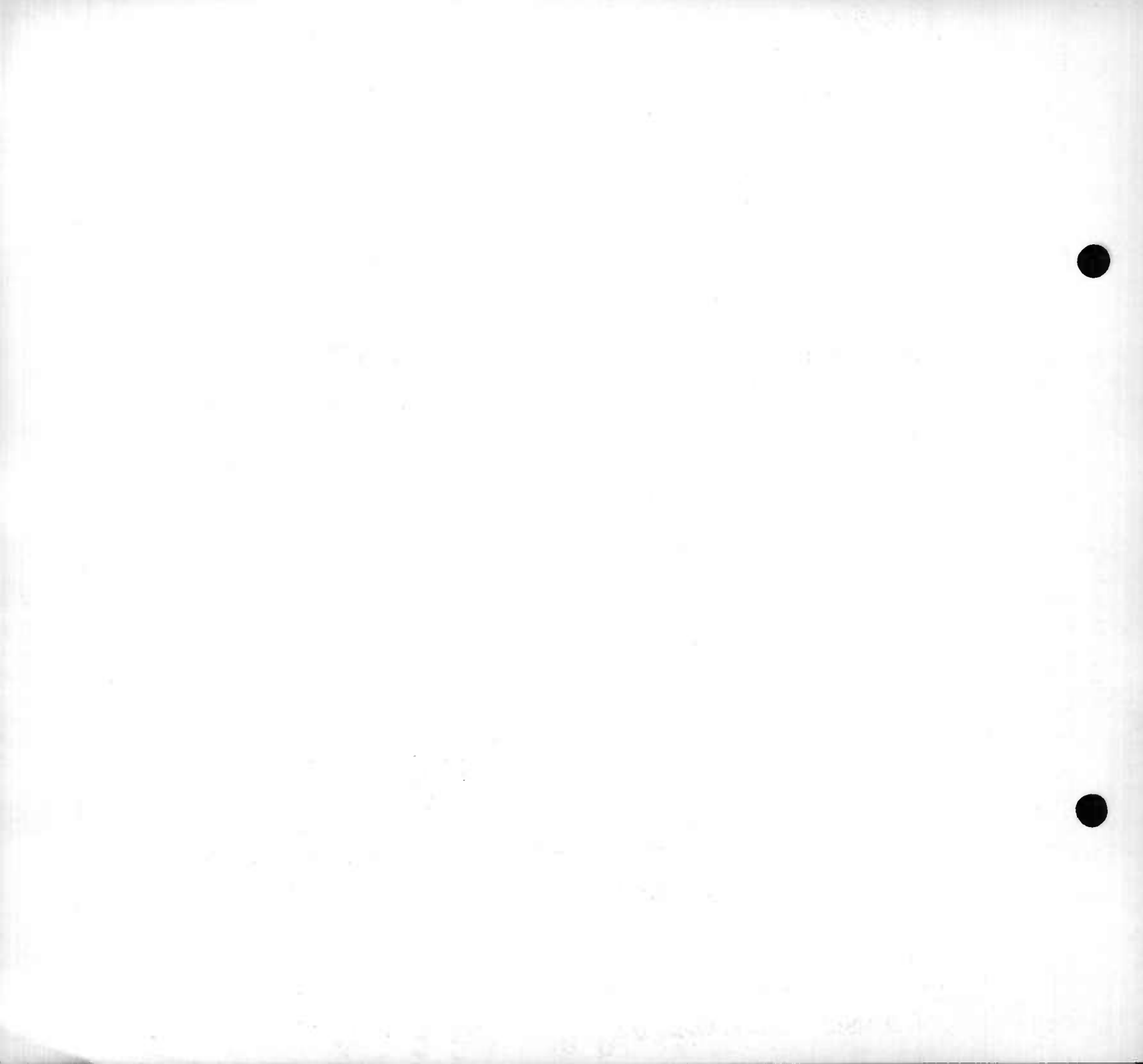
Baltimore City Health Department				REG. NO. 70 5582	
P-412 70 5582		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		also Grace Elizabeth Phillips		May 27, 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
00 5146 Stafford Road Baltimore, Maryland 21229		Maryland		2531	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5146 Stafford Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-16-1905	64	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Wilson Ray		Eunice Grace German		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-36-0486		Severna Park, Md.	
				Mrs. Dorothy R. Arrington, Box 19X Route 1	
18. 4400 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Minutes	
ANTECEDENT CAUSES		(B) Calcific Aortic Stenosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from Jan 65 to 5/27 1970, that (I) last saw the deceased alive on 5/1 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. James Nolan		5/28/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. James Nolan		1 Mallow Hill Road, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	5-29-1970	Moreland Memorial Park Cem.	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 2 1970	Robert E. Fisher, Jr.	Howard H. Hubbard, 4107 Wilkens Ave. 21229			



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO.		70 5583		CERTIFICATE OF DEATH		X REG. NO.		70 5583			
1. NAME OF DECEASED (Type or Print) <i>Robert Taylor</i>						2. DATE AND HOUR OF DEATH <i>5-31-70 8:50 P M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>4-3</i>						A. STATE <i>Maryland</i>					
						B. COUNTY <i>AA</i>					
C. CITY OR TOWN <i>Baltimore</i>						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
						E. STREET AND NUMBER <i>121 Berlin Ave.</i> <i>21225</i>					
5. SEX <i>m</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-22-04</i>		9. AGE in years (last birthday) <i>66</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired?</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Md. State</i>		11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Taylor</i>						14. MOTHER'S MAIDEN NAME <i>Susie Lemon</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>428-07-3807A</i>		17. INFORMANT ADDRESS <i>Thelma A. Rose - 121 Berlin Avenue</i>					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastatic Lung Carcinoma.</i>											
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-29</i> 19 <i>70</i> to <i>5-31</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>5-31</i> 19 <i>70</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>(did not)</del> view the body after death.											
23A. SIGNATURE <i>Daniel M Howell</i>						DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>5-1-70</i>		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
DEGREE											
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>6-4-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Portor Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Bolton, Mississippi</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>				25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law 802 Madison Ave.</i>			





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5584	
BIRTH NO. 520 70 5584		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN EDWARD JONES</b>			2. DATE AND HOUR OF DEATH <b>MAY 29, 1970 9:15 P.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Ashburton Nursing Home 3520 N. Hilton Street</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1605</b>		
5. SEX <b>Male</b>		6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Separated</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>10-22-1894</b>	
13. FATHER'S NAME <b>Jerry Jones</b>		16. SOCIAL SECURITY NO. <b>217-07-3783</b>		9. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles City Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			17. INFORMANT ADDRESS <b>Annette Jones - 2414 Harlem Avenue</b>		
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>10 days</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct. 6, 1969</b> to <b>May 29, 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 26, 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham B. Hurwitz MD</b>				23B. DATE SIGNED <b>June 1, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ MD</b>				23D. ADDRESS <b>7501 Liberty Road, Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-4-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law 802 Madison Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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<p><b>BIRTH NO.</b> <span style="font-size: 1.2em;">P-626</span> <span style="font-size: 1.2em;">70</span> <span style="font-size: 1.2em;">5585</span></p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;"><b>Registered No.</b> <span style="font-size: 1.2em;">70</span> <span style="font-size: 1.2em;">5585</span></p>			
<p><b>M.E. CASE NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Mrs. Antoinette Parker</span> <span style="font-size: 1.2em;">(ANTOINETTE PARKER)</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">5/29/70</span> <span style="font-size: 1.2em;">4:35 A.M.</span></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">48 Maryland General Hosp.</span></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Maryland</span> <span style="font-size: 1.2em;">2653</span></p> <p><b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Baltimore</span></p> <p><b>D. STREET ADDRESS</b> (If rural, give location)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">4037 Sinclair Lane</span></p>	
<p><b>5. SEX</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Female</span></p>	<p><b>6. RACE</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Colored</span></p>	<p><b>7. MARRIED, NEVER MARRIED</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">WIDOWED, DIVORCED (specify)</span></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Married</span></p>	<p><b>8. DATE OF BIRTH</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">5-25-1919</span></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Domestic</span></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	<p><b>9. AGE</b> (In years (last birthday))</p> <p style="text-align: center;"><span style="font-size: 1.2em;">51</span></p>
<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Calvert Co., Maryland</span></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">U.S.A.</span></p>	
<p><b>13. FATHER'S NAME</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">James W. Graham</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Florence V. Gross</span></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">No</span></p>		<p><b>16. SOCIAL SECURITY NO.</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">213-34-8691</span></p>	<p><b>17. INFORMANT</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Mary P. Farmer - 803 George St.</span></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">571.8 I</span></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p style="text-align: center;"><b>CAUSE OF DEATH</b></p> <p>(A) <span style="font-size: 1.2em;">Hepatic Failure</span></p> <p style="text-align: center;"><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p>(B) <span style="font-size: 1.2em;">Cirrhosis of Liver - <del>the</del> Post-Necrotic</span></p> <p>(C) <span style="font-size: 1.2em;">Gastrointestinal Hemorrhage</span></p>	
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p><b>19A. DATE OF OPERATION</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">2</span></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">No</span></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Yes</span></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (APPROX.)</p> <p style="text-align: center;">(Month) (Day) (Year) (Hour)</p>	<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">5/23</span> <span style="font-size: 1.2em;">19 70</span> <b>to</b> <span style="font-size: 1.2em;">5/29</span> <span style="font-size: 1.2em;">19 70</span>, <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">5/29/70</span> <span style="font-size: 1.2em;">19 70</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Louis E. Brenner</span> <span style="font-size: 1.2em;">M.D.</span></p>			<p><b>23B. DATE SIGNED</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">5/29/70</span></p>
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p>			<p><b>23D. ADDRESS</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">M.D.</span></p>
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Burial</span></p>	<p><b>24B. DATE</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">6-3-70</span></p>	<p><b>24C. NAME of CEMETERY or CREMATORY</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Baltimore National</span></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p style="text-align: center;"><span style="font-size: 1.2em;">Baltimore, Maryland</span></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">JUN 2 1970</span></p>		<p><b>25B. NAME OF REGISTRAR</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span></p>	<p><b>25C. FUNERAL DIRECTOR</b></p> <p style="text-align: center;"><span style="font-size: 1.2em;">Charles R. Law</span> <span style="font-size: 1.2em;">802 Madison Ave.</span></p>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5586</span>	
BIRTH NO. <span style="font-size: 1.5em;">C-460</span>		70 5586		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CLARE, ROBERT DAVID</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 28, 1970</span> <span style="float: right;">2:20A .M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">ST. AGNES HOSPITAL</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTO. CO</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">333 HARLEM LANE-SHANGRI-LA NURSING HOME</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">01 28 77</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">93</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MINISTER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">RELIGIOUS</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PENNSYLVANIA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">RICHARD CLARE</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">KATHERINE (ZIEGLER)</span>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">182 36 8193</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">AVES. BALTIMORE, MD. 21229</span> <span style="font-size: 1.2em;">ST. AGNES HOSP-RECORDS-CATON &amp; WILKENS</span>	
18. <span style="font-size: 1.5em;">472X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ch. Pulmonary obstruction</span> <span style="font-size: 1.5em;">Emphysema</span>  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">D</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAY 21</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">MAY 28</span> 19 <span style="font-size: 1.2em;">70</span> that (X) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 28</span> 19 <span style="font-size: 1.2em;">70</span> and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Zaher A. Khan</span>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ZAHER A. KHAN</span>
23D. ADDRESS <span style="font-size: 1.2em;">CATON &amp; WILKENS AVES. BALTIMORE, MD. 21229</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			
24B. DATE <span style="font-size: 1.2em;">1-2-1970</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">St. John's Lutheran</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Abbottstown, Pa.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 2 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">H. Hubbard Funeral Home 4107 Wilkens Ave.</span>	

Stonehurst Ct. Apts  
Upper Bailey, Pa.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 5587	
C-200 70 5587		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) REBA COX		2. DATE AND HOUR OF DEATH 5-28-70 16:00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1035 COURTNEY RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/2/13	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stat. Clerk
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stat. Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 232-03-0702		17. INFORMANT ADDRESS W. Jackson 4813 Bowland Ave. 21206			
18. 519.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE RESPIRATORY DISEASE DUE TO, OR AS A CONSEQUENCE OF: (B) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 445 DAYS YEARS		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-22-1970 to 5-28-1970 that (I) (we) last saw the deceased alive on 5-28-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RUBEN DRJANSKI MD		23B. DATE SIGNED 5-28-70		23C. PHYSICIAN'S NAME (Type) RUBEN DRJANSKI MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-1-1970		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Glenburnie, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. Hubbard, Funeral Director 4107 Wilkens Ave			

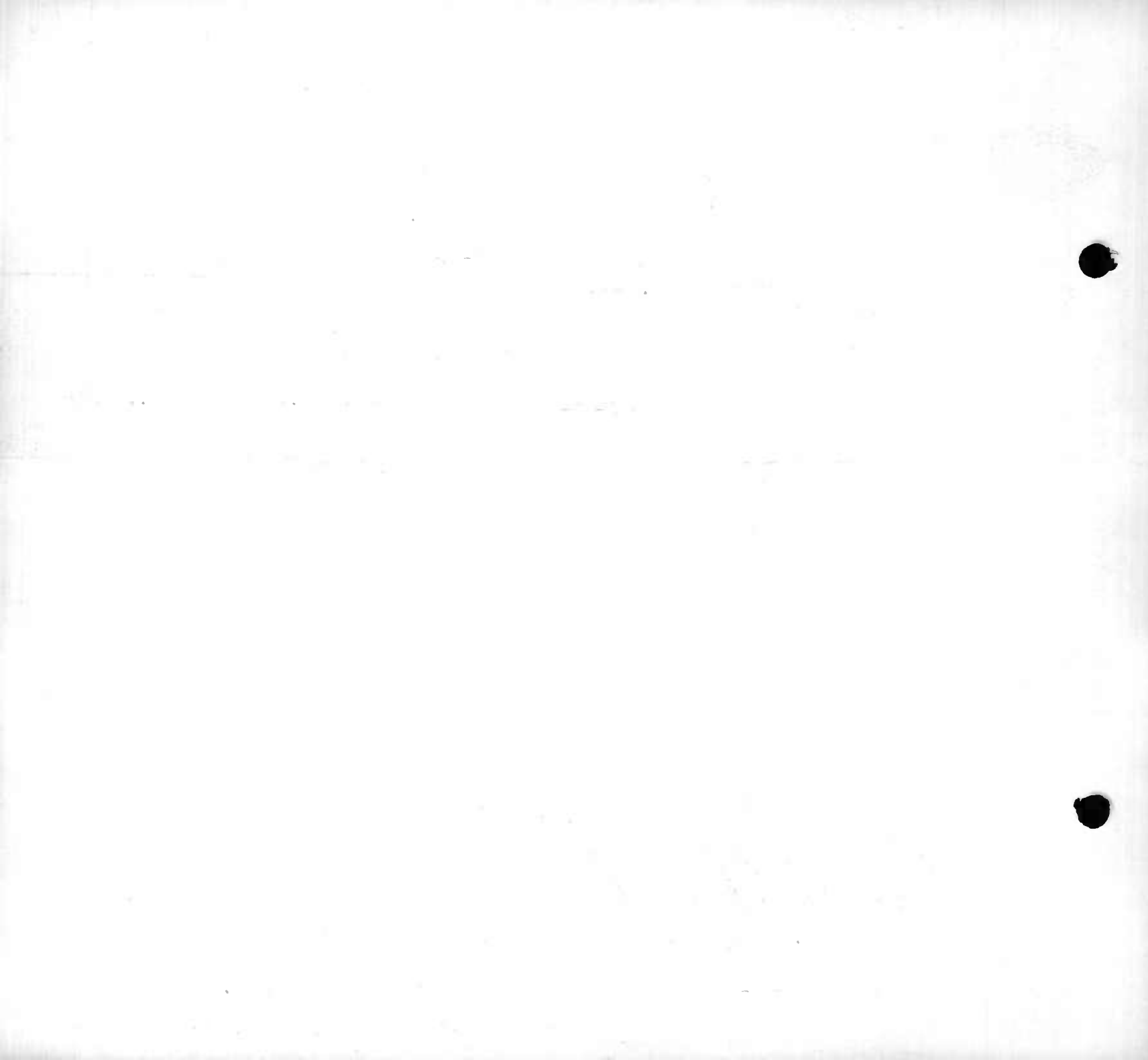




# FUNERAL DIRECTOR: IMPORTANT

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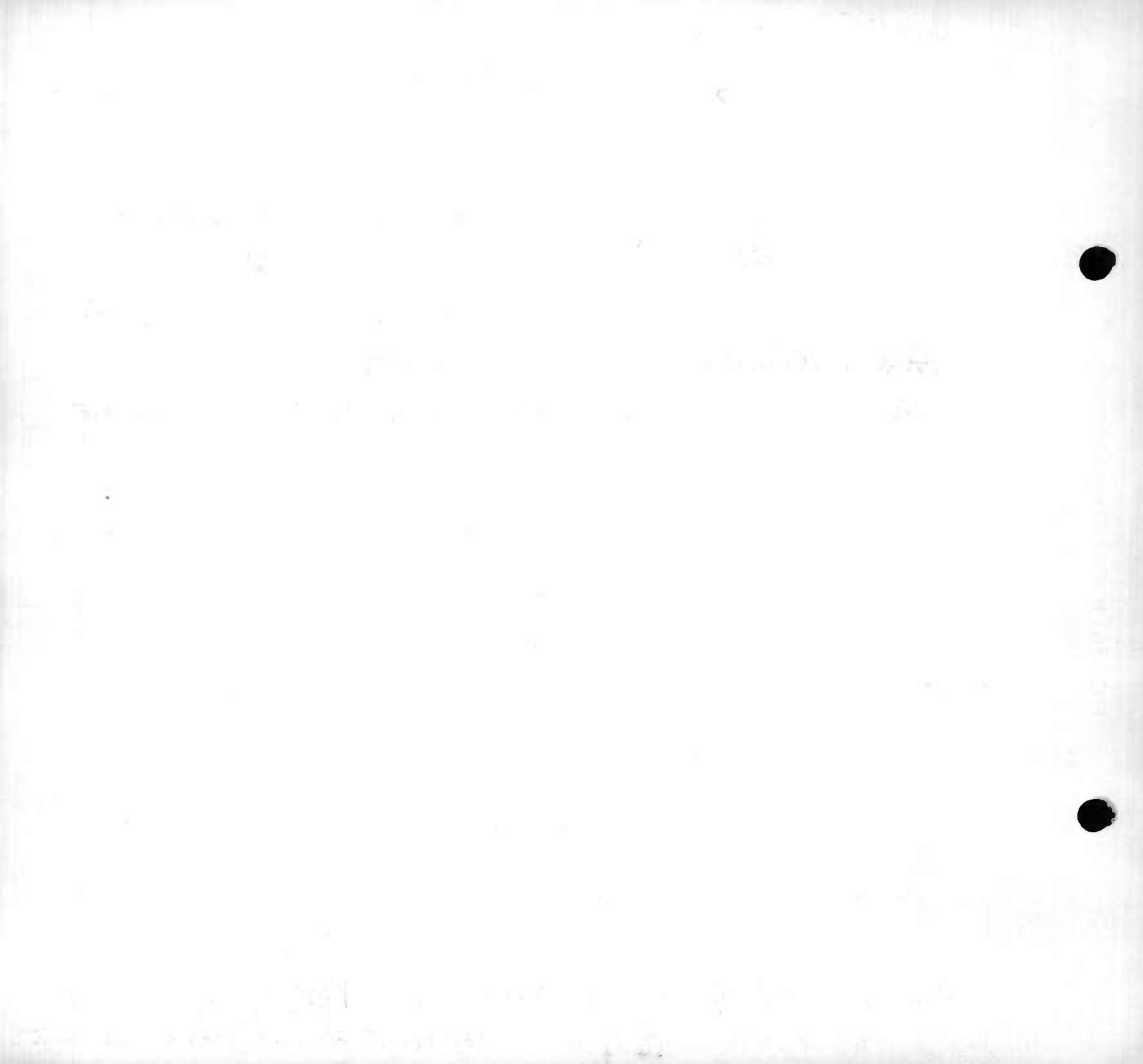
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 5588</span>	
0-620 70 5588		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>FRED OURECKY</b>		2. DATE AND HOUR OF DEATH <b>May 19, 1970</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Long Green Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>703</b>			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>90 Long Green Nursing Home</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-20-1879</b>		9. AGE (In years last birthday) <b>90</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. Carpenter Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Czech.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Anton Ourecky</b>			
14. MOTHER'S MAIDEN NAME <b>Marie Prochaska</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			
16. SOCIAL SECURITY NO. <b>218-22-0397T</b>		17. INFORMANT ADDRESS <b>Helen Neuner, dght., 7811 Oak Ave., 21234</b>			
18. <b>40.9 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerosis</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 19 68</b> to <b>May 19 70</b> that (I) (we) last saw the deceased alive on <b>May 17 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. G. Helfrich MD</i>				23B. DATE SIGNED <b>May 21, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. William Helfrich</b>				23D. ADDRESS <b>5006 Roland Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-22-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schmunek Funeral Home, 3331 Brehms Lane</b>			



# FUNERAL DIRECTOR: IMPORTANT

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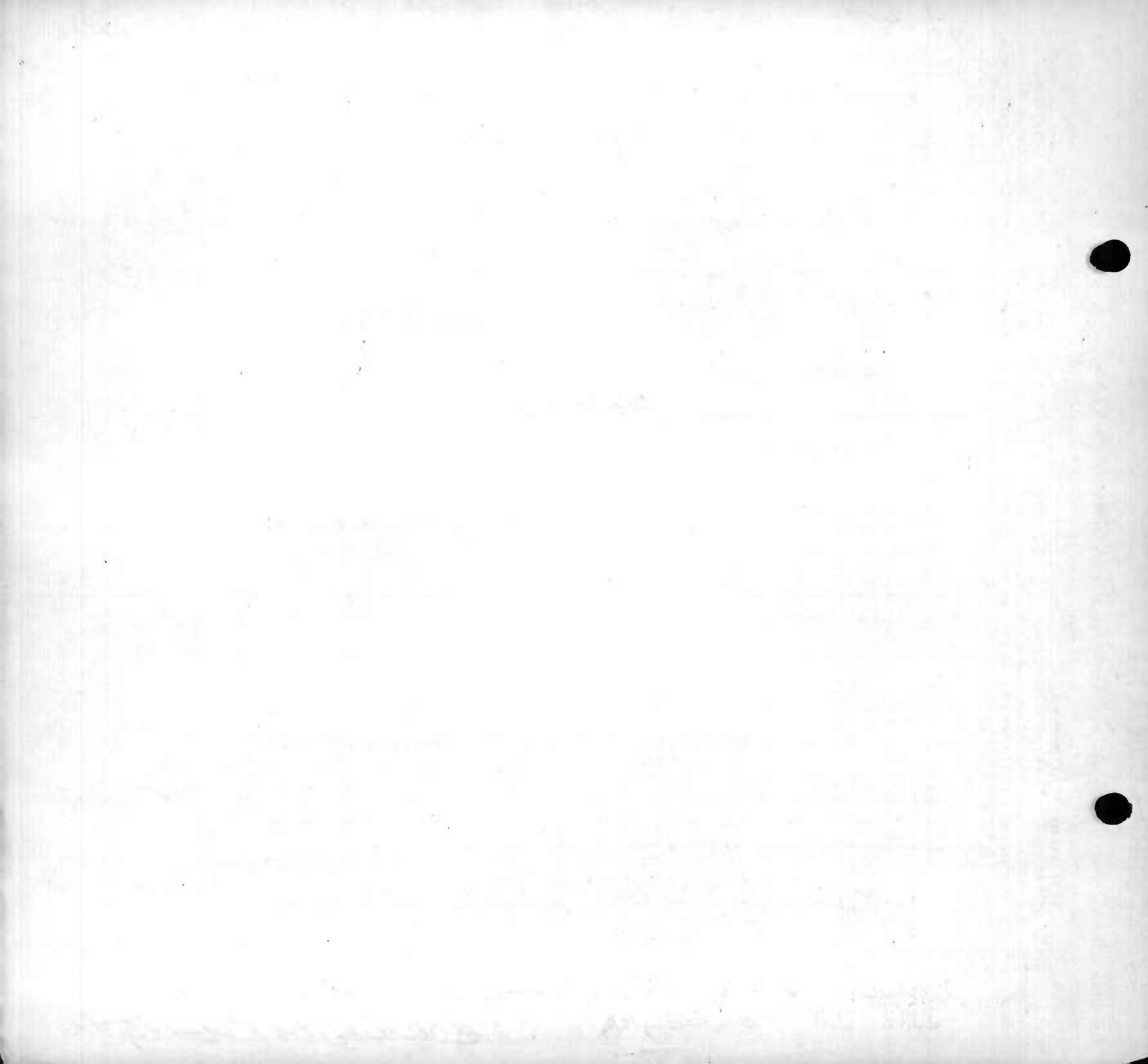
Baltimore City Health Department									
W-452 70 5589					70 5589				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, ARON JR. (ARON)</b>					2. DATE AND HOUR OF DEATH <b># 6/1/70 2:20 A. M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp.</b>					A. STATE <b>MD</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY <b>1901</b>				
					C. CITY OR TOWN <b>Baltimore</b>				
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <b>1417 W. Mulberry St.</b>				
5. SEX <b>MALE</b>		6. RACE <b>NEGROID</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-1909 (62) (62)</b>		9. AGE (in years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ARON Williams</b>					14. MOTHER'S MAIDEN NAME <b>Betty</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>238-24-7209</b>		17. INFORMANT <b>Elenora Williams</b>		ADDRESS <b>SAME</b>			
18. <b>458.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>hypotension - Bacteremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>shock (Bacteroides)</b> <b>Acute pulmonary edema 20 days</b> <b>and Bleeding External Hemorrhoids.</b>					CAUSE OF DEATH <b>shock (Bacteroides)</b> <b>Acute pulmonary edema 20 days</b> <b>and Bleeding External Hemorrhoids.</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASHED</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>5/12/1970</b> to <b>6/1/1970</b> that (I) (we) last saw the deceased alive on <b>5/31/1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Subash C. Ahuja MD</b>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6/1/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>SUBASH C. AHUJA MD</b>					23D. ADDRESS <b>Lutheran Hosp. Balt. MD 2146</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-7-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Church Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Warrenton, N.C.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>V. BAILEY</b>		ADDRESS <b>KELSON F. H. 1348 CALHOUN ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>70 5590</u>	
BIRTH NO. <u>H-620 70 5590</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>MAY 28-1970 9:45 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Estella Harris</u>		A. STATE <u>md.</u> B. COUNTY <u>2562</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2805 Round Rd</u> <u>00</u>		C. CITY OR TOWN (All outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>2805 Round Road</u>	
5. SEX <u>Female</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>12-28-1880</u>
9. AGE (In years last birthday) <u>89 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Katie Williams</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-2306</u>	17. INFORMANT ADDRESS <u>Sarah Rice, same.</u>
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Carcinoma of Lungs</u> DUE TO (B) <u>Arteriosclerotic Heart</u> DUE TO (C) <u>Peptic Ulcer.</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs.</u> <u>16 yrs.</u> <u>16 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Asthma</u>		<u>16 yrs</u>	
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>MAY 28, 1970</u> , that (I) (we) last saw the deceased alive on <u>MAY 20, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jerry C. Luck</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>May 28, 1970</u>
23C. PHYSICIAN'S NAME (Type) <u>Jerry C. Luck</u> M.D.		23D. ADDRESS <u>427 Swale Rd, Balto. Md</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-2-70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cent</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>1000 Pennsylvania Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.2em;">70 5591</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">A-260 70 5591</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">May 27<sup>th</sup> 1970</span>		
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">James Acree</span>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">1825 W. Saratoga St.</span>		
<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2001</span>		<b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">Colored</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Aug. 11, 1907</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">62</span>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Halifax Co. VA.</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">James Acree</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Sally Ayres</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">579-16-8805</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mary Acree</span>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">Undifferentiated broncho-genic carcinoma of right lung</span> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">3 years</span>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Sept 1967</span> <b>19</b> <b>to</b> <span style="font-size: 1.2em;">May 8</span> <b>19</b> <b>70</b> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">May 27</span> <b>19</b> <b>70</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">James Acree M.D.</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">5/29/70</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">James Acree M.D.</span>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6-1-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Mt. Auburn Cem.</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 2 1970</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">E. L. Boyer</span>		
<b>25D. ADDRESS</b> <span style="font-size: 1.2em;">1000 Brantley Ave</span>				

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Handwritten text, possibly a date or reference number.

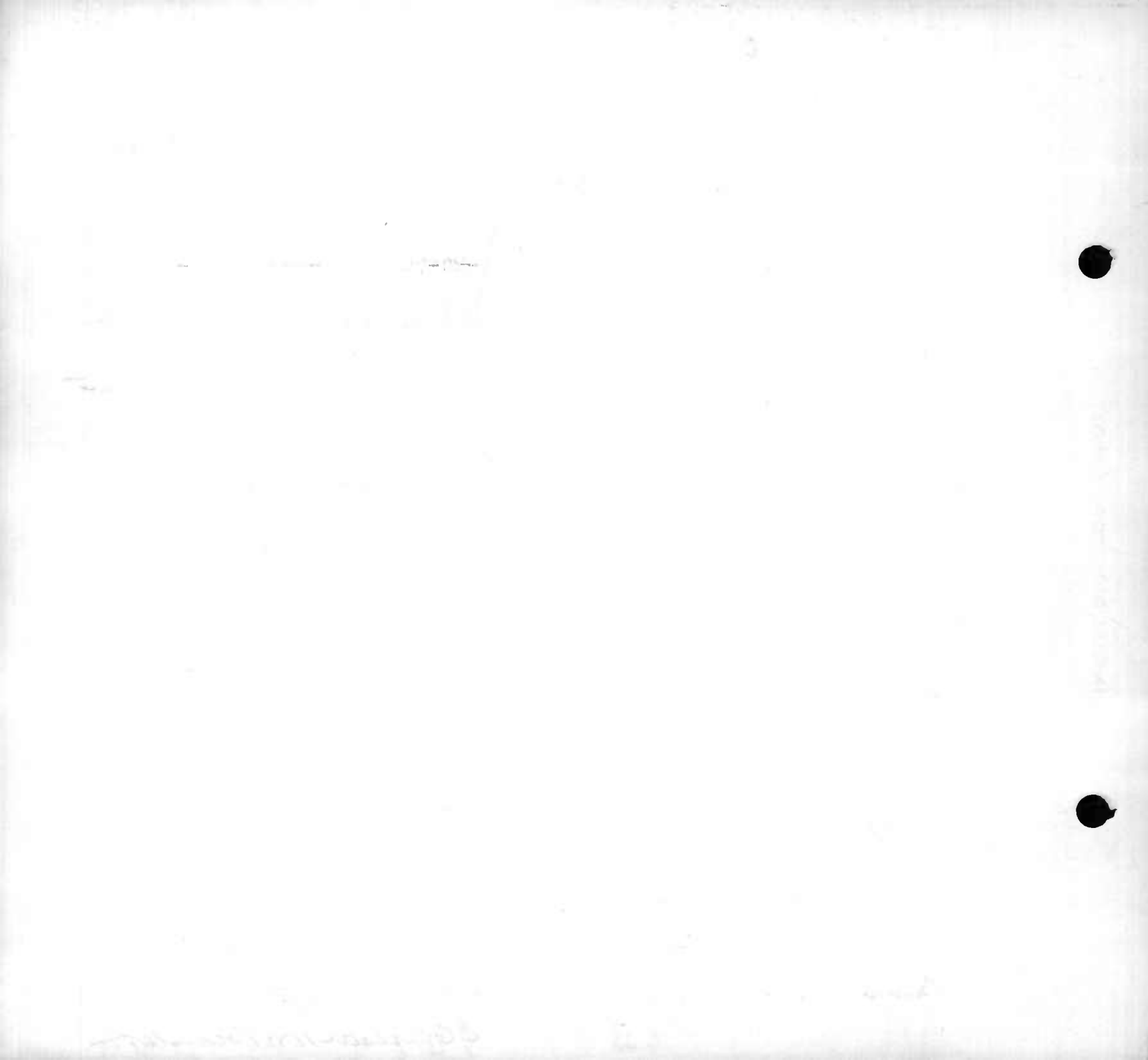
Handwritten signature or name.



# FUNERAL DIRECTOR: IMPORTANT

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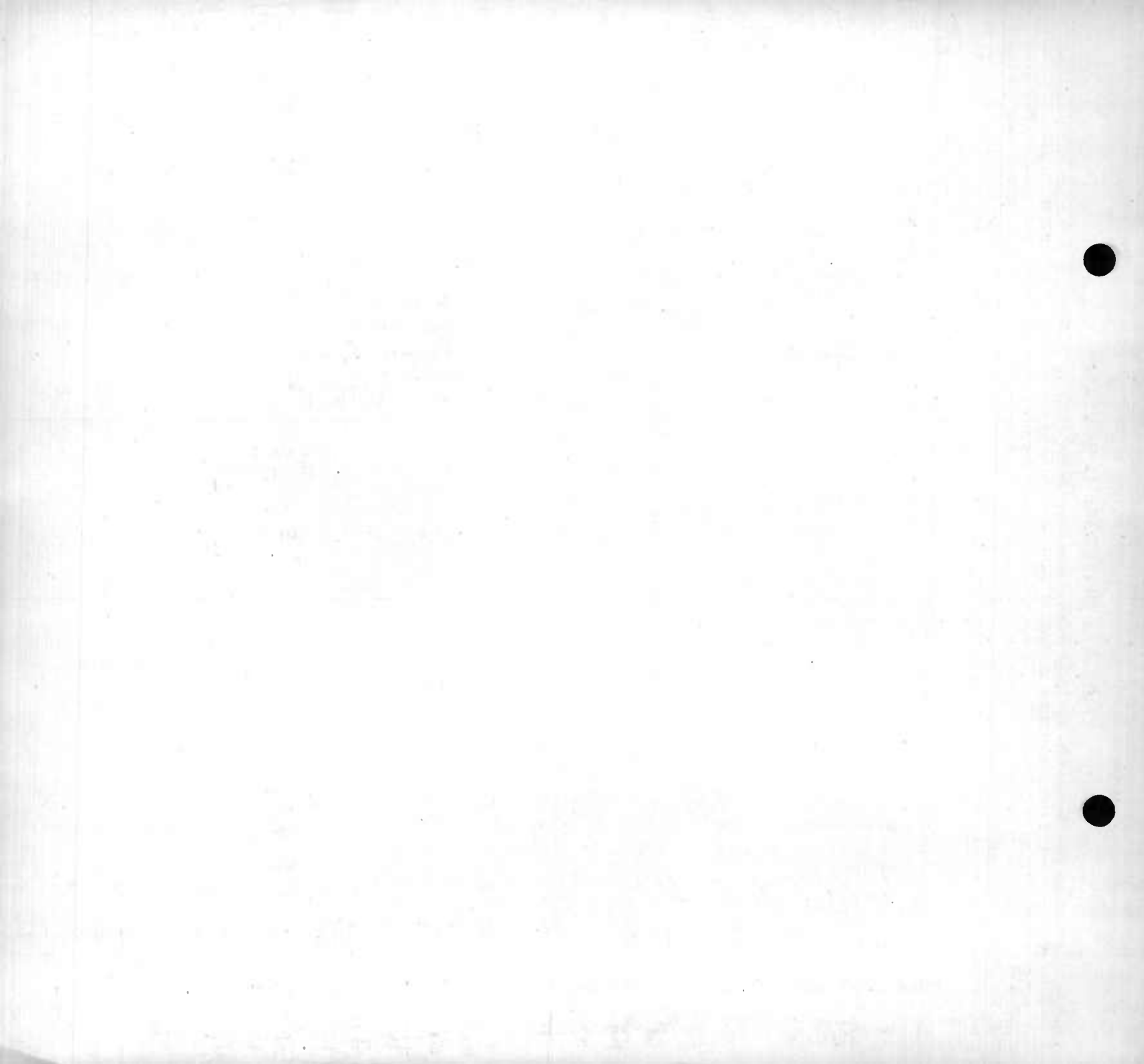
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5592	
BIRTH NO. 70-08990				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL ANDERSON B</u>				2. DATE AND HOUR OF DEATH <u>5/27/70 400 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>BALTIMORE CITY</u>	
C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1540 N. BROADWAY</u>							
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-21-70</u>	9. AGE (in years last birthday) <u>6</u>	If Under 1 Yr. Months: <u>6</u> Days: <u>6</u>		If Under 24 Hrs. Hours: <u>6</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>EUGENE ANDERSON</u>				14. MOTHER'S MAIDEN NAME <u>VALERIE RICHARDSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Valerie Anderson</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory insufficiency</u>		<u>1 hr.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) POSSIBLE SEPSIS		<u>26 hr</u>	
				(C) <u>Septicemia or blood exchange or acidosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> 19 <u>70</u> to <u>5/27</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>May 27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Judith Hall</u>				23B. DATE SIGNED <u>5/27/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>JUDITH HADL</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-2-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balti Nat Cent</u>		24D. LOCATION (City, town, or county) (State) <u>Balti Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Edgar 1000 Broadway</u>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5593</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Johannes Opdahl</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">May 31, 1970</span> <span style="float: right;">6:30 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">US Public Health Service Hospital</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">906</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore 21218</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1901 E. 32nd Street</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Cauc.</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">July 29, 1896</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">73</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Engineer</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">seafarer</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Norway</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Ole Opdahl</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Helen Godo</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">none</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">186 18 4731</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Records - USPHS Hospital, Baltimore, Md.</span>
<b>18. CAUSE OF DEATH</b> <span style="font-size: 1.5em;">410.9 I</span> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">5 days</span>  <span style="font-size: 1.2em;">years</span>
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">yes</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">July 17</span> 19 <span style="font-size: 1.2em;">57</span> to <span style="font-size: 1.2em;">May 31</span> 19 <span style="font-size: 1.2em;">70</span> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 31</span> 19 <span style="font-size: 1.2em;">70</span> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Samuel P. Ward M.D.</span>			<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">May 31, 1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Samuel P. Ward M.D.</span>			<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">USPHS Baltimore Hospital, Baltimore, Md.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Cremation June 3, 1970</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">June 3, 1970</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Greenmount Crematorium</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 2 1970</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">George Sanders Son Jr</span>		



1

70 5594

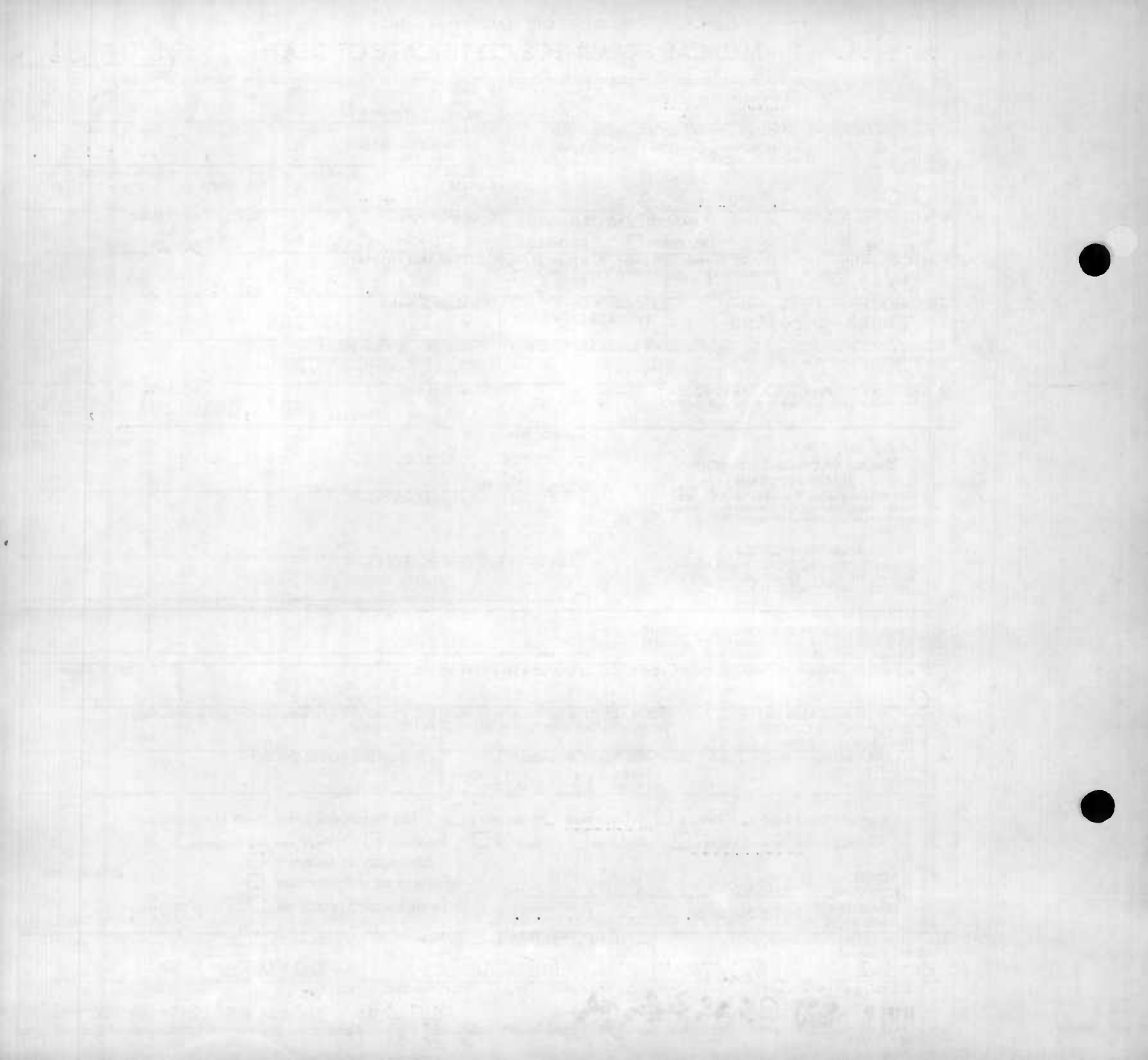
BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 70 5594

BIRTH NO. 2-250

1. NAME OF DECEASED (Type or Print) <b>LILLIE LOGAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>443 W. Biddle Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>May 28, 1970</b> 11:15 A.M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6/15/09</b>		10. AGE (In years lost birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	
15. MOTHER'S MAIDEN NAME <b>SALLY BROOMFIELD</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>MRS SAVANAH JONES, 304 E 101 St, N Y</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED <b>May 28, 1970</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/3/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W north Av</b>	

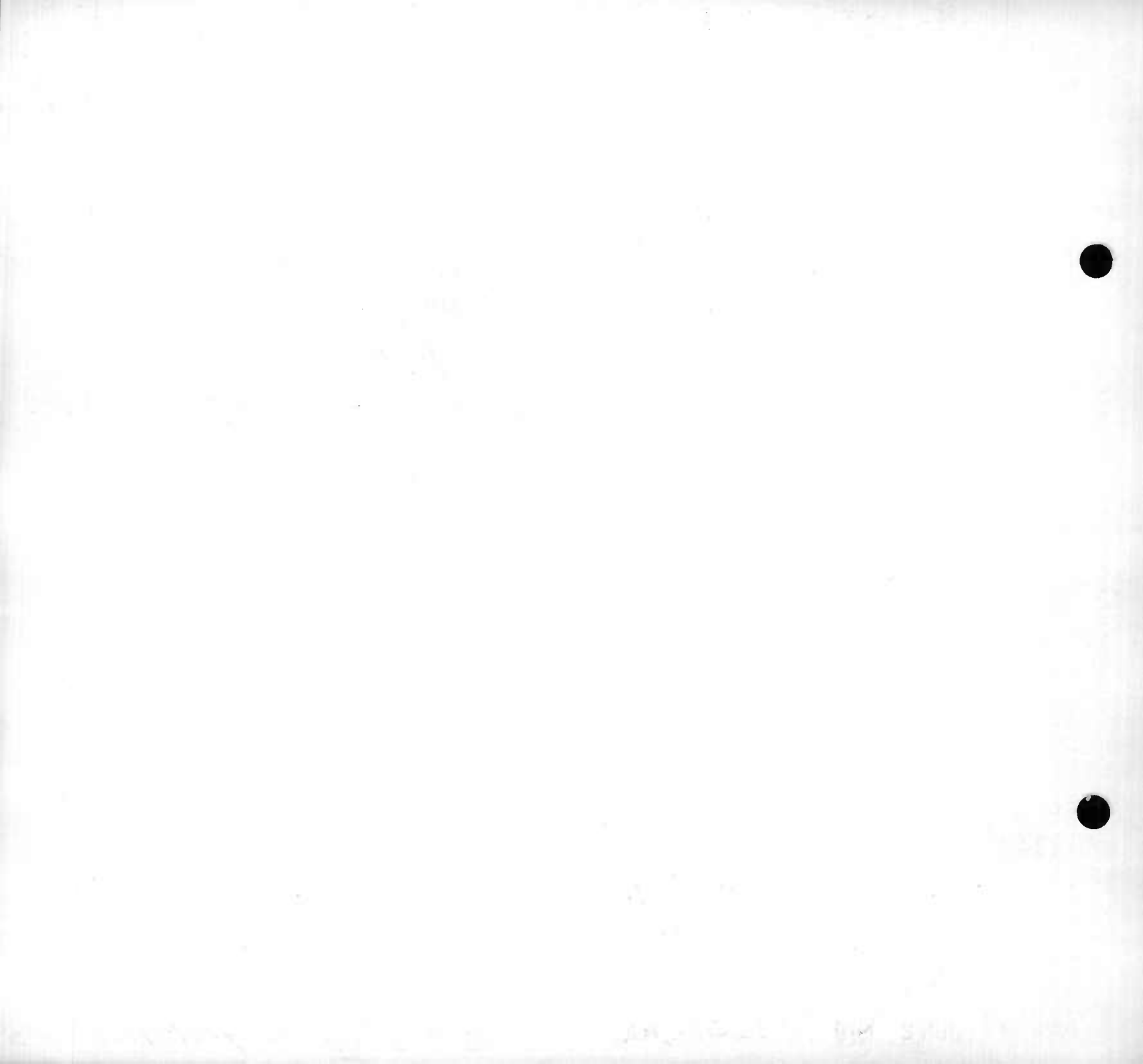
VS 151-REV. 7/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 5595		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5595	
1. NAME OF DECEASED (Type or Print) <u>JOSEPH Scott, JR.</u>		2. DATE AND HOUR OF DEATH <u>5/28/70</u> <u>3 45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIV. MD. BALT. MD.</u>		C. CITY OR TOWN <u>BALT</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1217 E. FEDERAL STREET</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/30/16</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CITY SANITATION</u>		11. BIRTHPLACE (State or foreign country) <u>Halifax Co. V.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH SCOTT, SR</u>		14. MOTHER'S MAIDEN NAME <u>ADA ADAMS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>226-12-7776</u>		17. INFORMANT <u>Hallie Scott</u> ADDRESS <u>same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>5/19/70</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY ABSESS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>CHRONIC OBSTRUCTIVE pulm disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10 yrs</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5/28/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/28/70</u> 19 <u>70</u> to <u>5/28/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/28/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard Wallach, MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>HOWARD WALLACH, MD</u>		23D. ADDRESS <u>UNIV. MD. HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	24B. DATE <u>5/29/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		24D. LOCATION (City, town, or county) (State) <u>South Boston V.A.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	25C. FUNERAL DIRECTOR <u>Hallie Scott</u>		ADDRESS <u>1727 N. Maryland St.</u>	

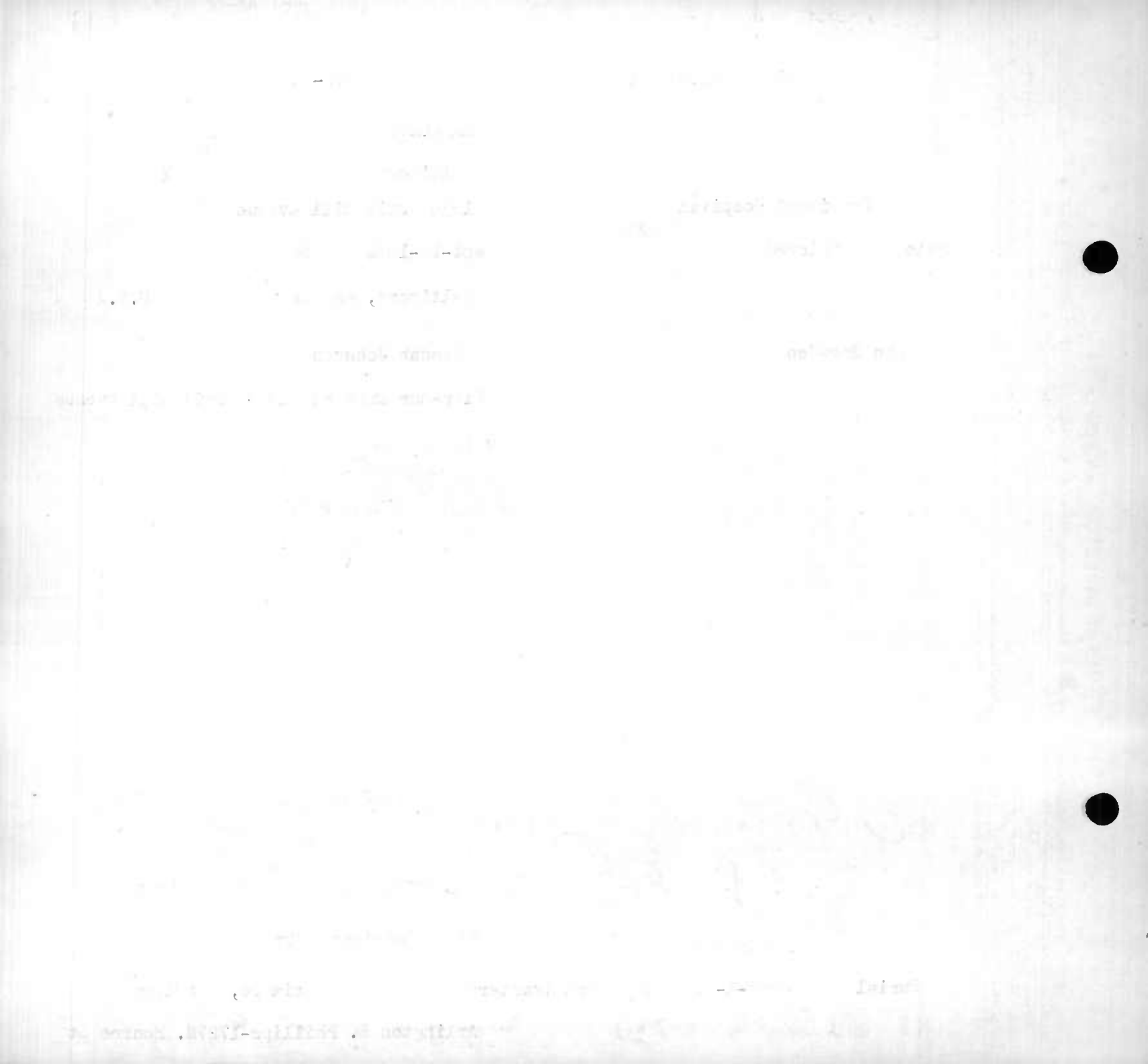




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

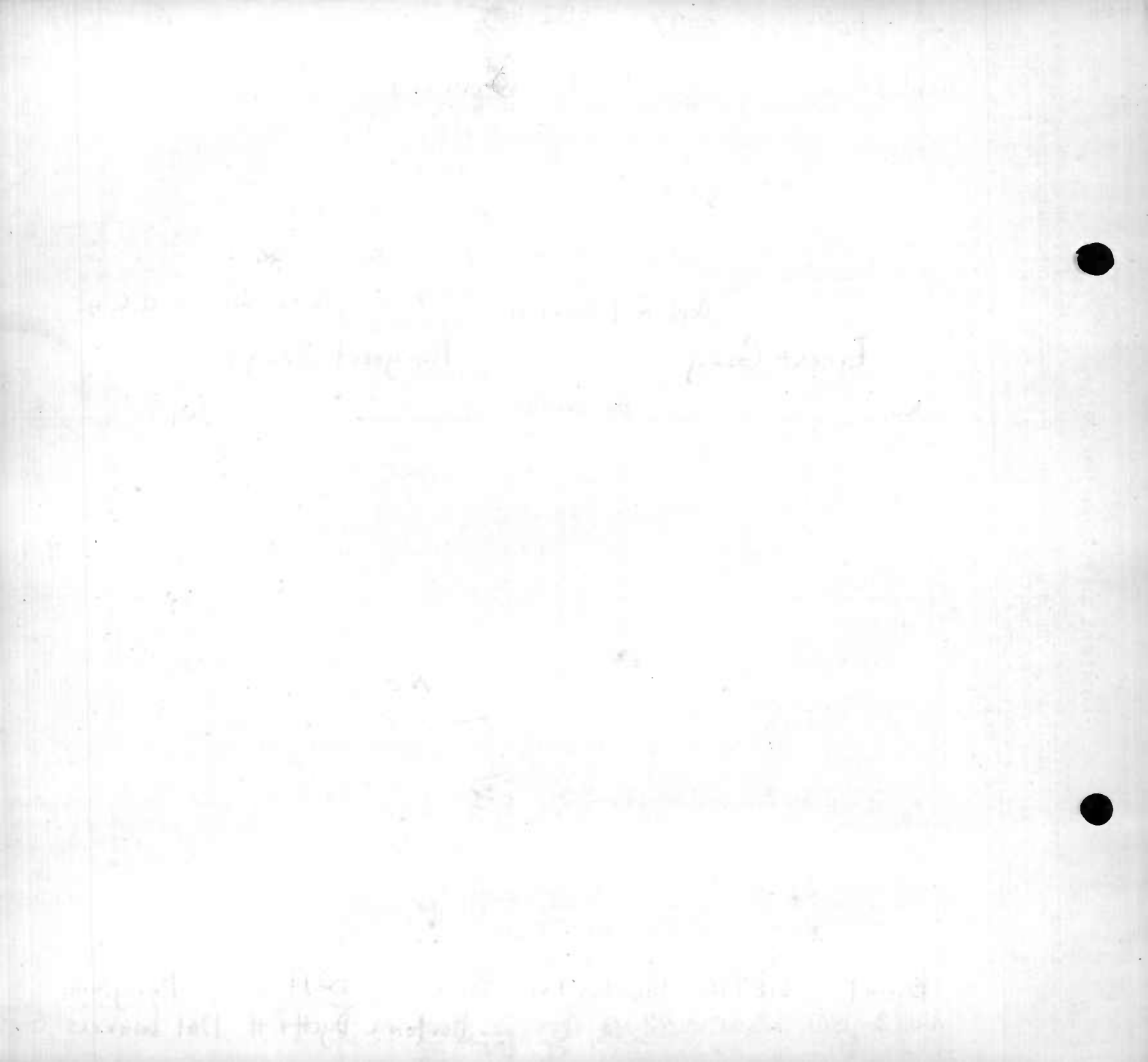
S-535 70 5596				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5596	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				John Wesley Snowden		May 27- 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		810 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital				A. STATE Maryland		1403	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY		D. INSIDE CITY LIMITS?	
				C. CITY OR TOWN Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1930 Druid Hill Avenue			
5. SEX Male		6. RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept-28-1894	
						9. AGE (In years lost birthday) 86	
						10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Snowden				14. MOTHER'S MAIDEN NAME Hannah Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Florence Snowden 1930 Druid Hill Avenue	
						ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH ASTHMA & acute myocardial infarction & cigarette Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/25/70 to 5/27/70, that (I) (we) last saw the deceased alive on 5/27/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Elijah Saunders				23B. DATE SIGNED 5/29/70			
23C. PHYSICIAN'S NAME (Type) Elijah Saunders				23D. ADDRESS 23 00 Garrison Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June-1-70		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arlington S. Phillips		25D. ADDRESS 1727N. Monroe St	



# FUNERAL DIRECTOR: IMPORTANT

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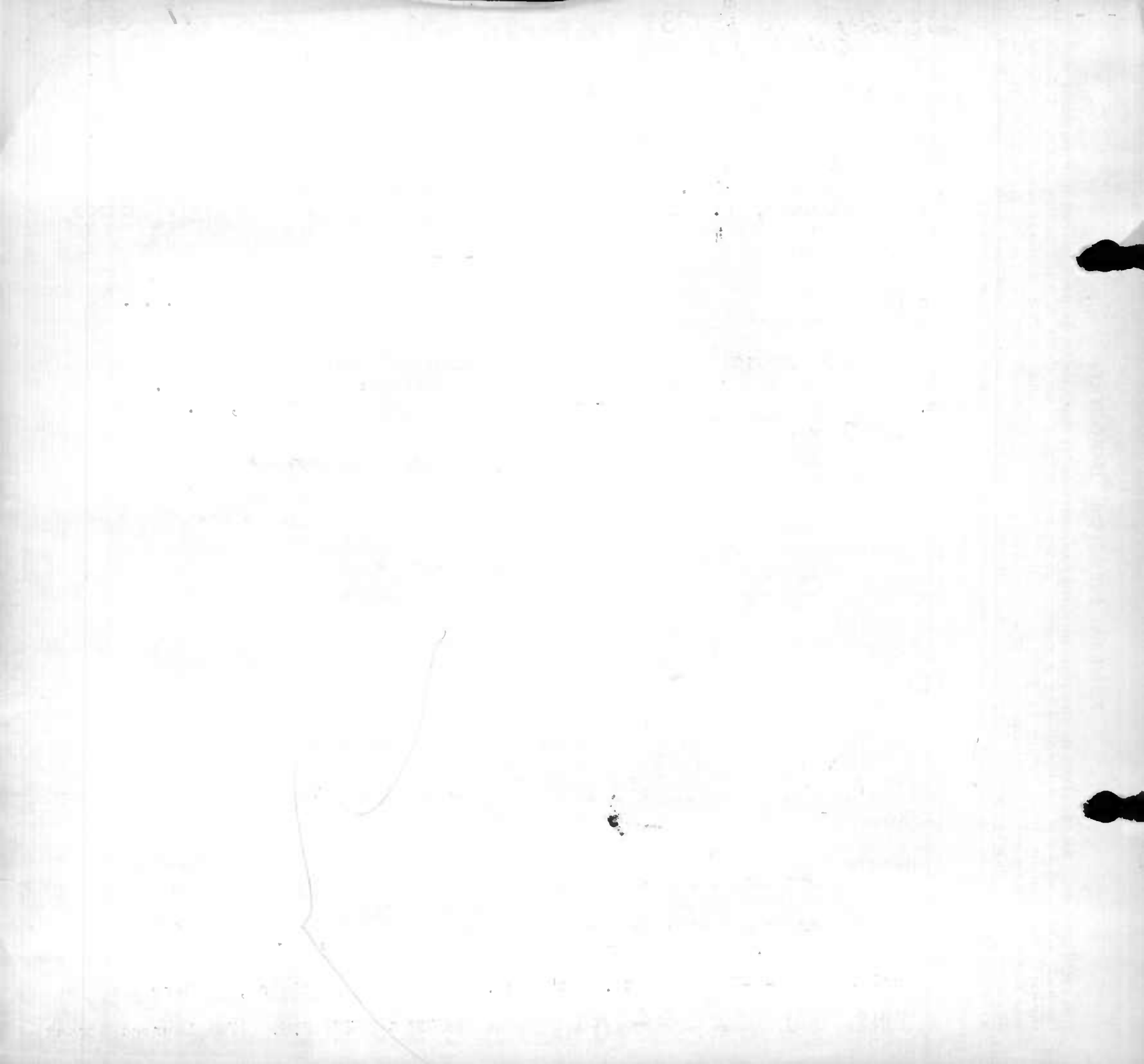
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
2-162 70 5597		70 5597		M.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADELL JEFFRIES (Jeffries)</b>		2. DATE AND HOUR OF DEATH <b>6/1/70 1:30</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1606</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2922 ARUNAIT AVE.</b>	
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-8-30</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Education</b>		11. BIRTHPLACE (State or foreign country) <b>N.C., Greensboro</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ernest Gray</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Gray</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>238-24-6913</b>		17. INFORMANT <b>COUSIN 3435 WABASH AVE. BALTO.</b>	
18. <b>16211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA LUNG</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/30</b> 19 <b>70</b> to <b>6/1</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>6/1</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>KWIN</b>		23B. DATE SIGNED <b>6/1/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>KYL KYI LWIN</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/6/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Montford Dyett F. H.</b>			
		ADDRESS <b>1701 Laurens St.</b>			



## FUNERAL DIRECTOR: IMPORTANT

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J-525 70 5598		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 5598	
BIRTH NO.		M.E. CASE NO. 64-13930		1. NAME OF DECEASED (Type or Print) JOHNSON MARVIN J.	
2. DATE AND HOUR OF DEATH 5/28/70 @ 1:30 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5300 D. STREET ADDRESS (If rural, give location) 555 Pittsburg Ave 005 21222			
5. SEX Negro M	6. RACE Male C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-30-64	9. AGE (In years last birthday) 5	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WALTER JOHNSON			
14. MOTHER'S MAIDEN NAME Constance Cook		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO. -0-		17. INFORMANT BCHA Records: 4940 Eastern Ave. Baltimore, Md. 21224			
18. 207.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) CARDIO-RESPIRATORY ARREST DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) SEPTICEMIA + OBSTRICTIONS DUE TO FATAL HEMORRAGIA			
		(C) LEUKEMIA.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 20, 1970 to May, 28, 1970, that (I) (we) last saw the deceased alive on May, 28, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Alvarez R.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May, 28, 1970	
23C. PHYSICIAN'S NAME (Type) M. ALVAREZ R.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-1-70		24C. NAME of CEMETERY or CREMATORY Balto. Nat'l Cem.	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5599	
G-600 70 5599					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Telesko Gray</b>			2. DATE AND HOUR OF DEATH <b>5-26-70 11<sup>25</sup> pm M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Plaza Manor Nursing Home</b> <b>4615 Park Heights Ave</b>			A. STATE <b>Md</b> B. COUNTY <b>21230 2543</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>2517 Huron St</b>		
5. SEX <b>m</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.20.11</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth-Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Chesler, South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elliott Gray</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Gray</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-01-1941</b>		17. INFORMANT <b>Mrs. Mary M. Gray</b> ADDRESS <b>2517 Huron St.</b>	
18. <b>1519 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
(A) IMMEDIATE CAUSE <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF: <b>12 hrs.</b>					
(B) <b>ASCD-</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Ca. of Stomach: int. test.</b> <b>3/13/70</b>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>3/30/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Crop stomach</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(I)</b> <del>(this hospital)</del> attended the deceased from <b>4-27</b> 19 <b>70</b> to <b>5-27</b> 19 <b>70</b> , that <b>(I)</b> <del>(we)</del> last saw the deceased alive on <b>5/19</b> 19 <b>70</b> and that in <b>(my)</b> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <del>(We)</del> <del>(did)</del> view the body after death.					
23A. SIGNATURE <b>H.B. Scott MD</b>		23B. DATE SIGNED <b>5/27/70</b>		23C. PHYSICIAN'S NAME (Type) <b>H.B. Scott</b>	
23D. ADDRESS <b>721 Medical Arts Bldg.</b>		23E. DEGREE <b>MD</b>		23F. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>6/1/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (City, town, or county) <b>Baltimore</b>		24F. (State) <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>	
25D. ADDRESS <b>1701 Laurens St</b>		25E. (City, town, or county) <b>Baltimore</b>		25F. (State) <b>Md</b>	





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5600</u>	
C-200 70 5600		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SULLIVAN CHEEKS		5-29-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 1411 Poplar Grove Street			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1411 Poplar Grove Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-1898	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Clinton, South Carolina	
13. FATHER'S NAME Sanford Cheeks		14. MOTHER'S MAIDEN NAME Mary A. Cheeks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 073-30-5855		17. INFORMANT Mrs. Banner Dunlop	
				ADDRESS 1411 Poplar Grove St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 201X I Hodgkins' Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hodgkins' Disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			MAINTAINATION		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-3-1970 to 5-29-1970 that (I) (we) last saw the deceased alive on 5-8-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice L. Adams			23B. DATE SIGNED 5-29-70		23C. PHYSICIAN'S NAME (Type) MAURICE L. ADAMS
23D. ADDRESS 238 N. CAREY ST.			23E. DEGREE DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-3-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
				ADDRESS 1701 Laurens Street	

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5601</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5601</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Benjamin F Williams</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 1 - 1970</span> <span style="font-size: 1.5em;">7 30 P M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2002</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">34 Bon Sacours Hosp</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">2101 Penrose Ave.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/1/87</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">83</span>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">retired Policeman</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Lima, Ohio</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Roland Williams</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Jones</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wpr or dates of service) <span style="font-size: 1.2em;">Yes</span> <span style="font-size: 1.2em;">WAVE</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-28-3678</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Virginia Williams</span>
18. <span style="font-size: 1.5em;">2509 I</span>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Coronary Thrombosis</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Diabetes</span>		
			(C) <span style="font-size: 1.5em;">Coronary Vasculodisorder</span>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.5em;">Atherosclerosis</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">June 1968</span> to <span style="font-size: 1.2em;">May 10 1970</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 10 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Charles A Cahn</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">6/2-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Charles A CAHN</span>				23D. ADDRESS <span style="font-size: 1.2em;">2145 W Baltimore St</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/4/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, MD.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 2 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Wm E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm B. Balwant, Jr.</span>	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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70 5602 CERTIFICATE OF DEATH				REG. NO. 70 5602	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James F. Marhefka		June 1, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen Hosp			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 2302		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1516 S. Hanover St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1914	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Hochschild/Kohn		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Stanislaw Marhefka		14. MOTHER'S MAIDEN NAME Thelma Tamowski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-7554		17. INFORMANT Mrs. Katherine M. Marhefka	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction Sudden death		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-15-68 to 5/23/70, that (I) (we) last saw the deceased alive on 5/23/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George McLean			23B. DATE SIGNED 6/2/70		23C. PHYSICIAN'S NAME (Type) GEORGE MCLEAN
23D. ADDRESS 705 Med. Arts Bldg			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6/4/70			24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		
24D. LOCATION Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		
25D. ADDRESS 538 East Fort Avenue					

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

1960-1961

1961-1962

1962-1963

1963-1964

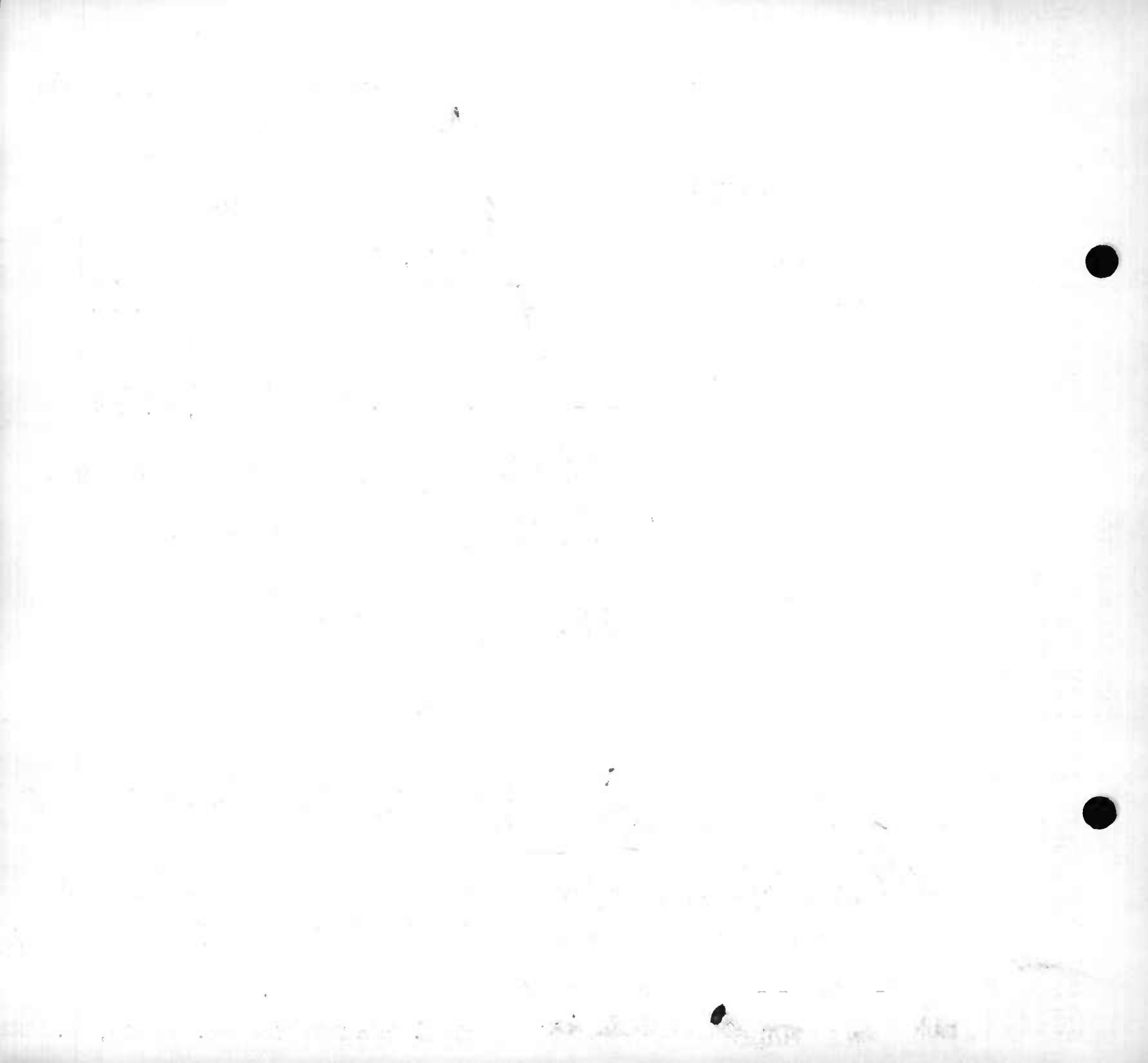
1964-1965

1965-1966

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
70 5603 CERTIFICATE OF DEATH					REG. NO. 70 5603				
BIRTH NO.					1. NAME OF DECEASED (Type or Print) DORA J. TINKER				
2. DATE AND HOUR OF DEATH June 2, 1970 6:05 A.M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD NURSING HOME					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Colorado B. COUNTY Boulder V-05				
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH July 28, 1876 9. AGE (in years last birthday) 93				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) COLORADO					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ROBERT TINKER					14. MOTHER'S MAIDEN NAME CARRIE BUTTS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 523-54-0589				
17. INFORMANT (Son) Mr. Lloyd A. Tinker					2349 Searles Road Dundalk, Md. 21222 ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.21 Arteriosclerosis (uremia) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C-V disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Glaucoma (bilateral)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from May 17, 1970 to June 2, 1970 that (I) (we) last saw the deceased alive on June 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE H.V. Harbold M.D.					23B. DATE SIGNED 6/2/70				
23C. PHYSICIAN'S NAME (Type) H.V. HARBOLD M.D.					23D. ADDRESS 4706 HARBOLD ROAD Baltimore Maryland 21214				
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial					24B. DATE 6-5-70				
24C. NAME OF CEMETERY OR CREMATORY Green Mountain					24D. LOCATION (City, town, or county) (State) Boulder, Colorado				
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				
25C. FUNERAL DIRECTOR John E. Duda					ADDRESS 7922 Wise Ave. Dundalk, Md. 21222				

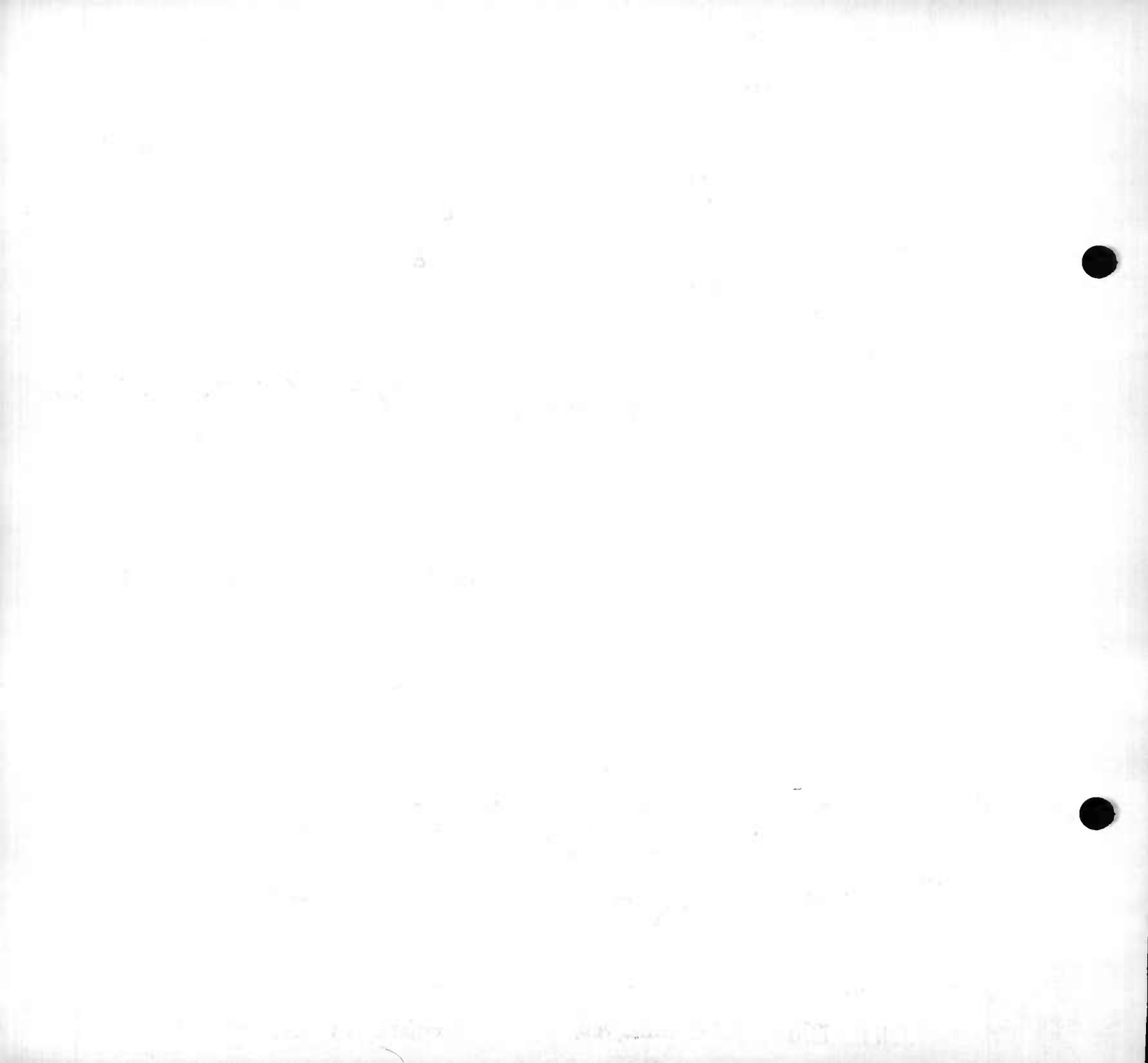




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

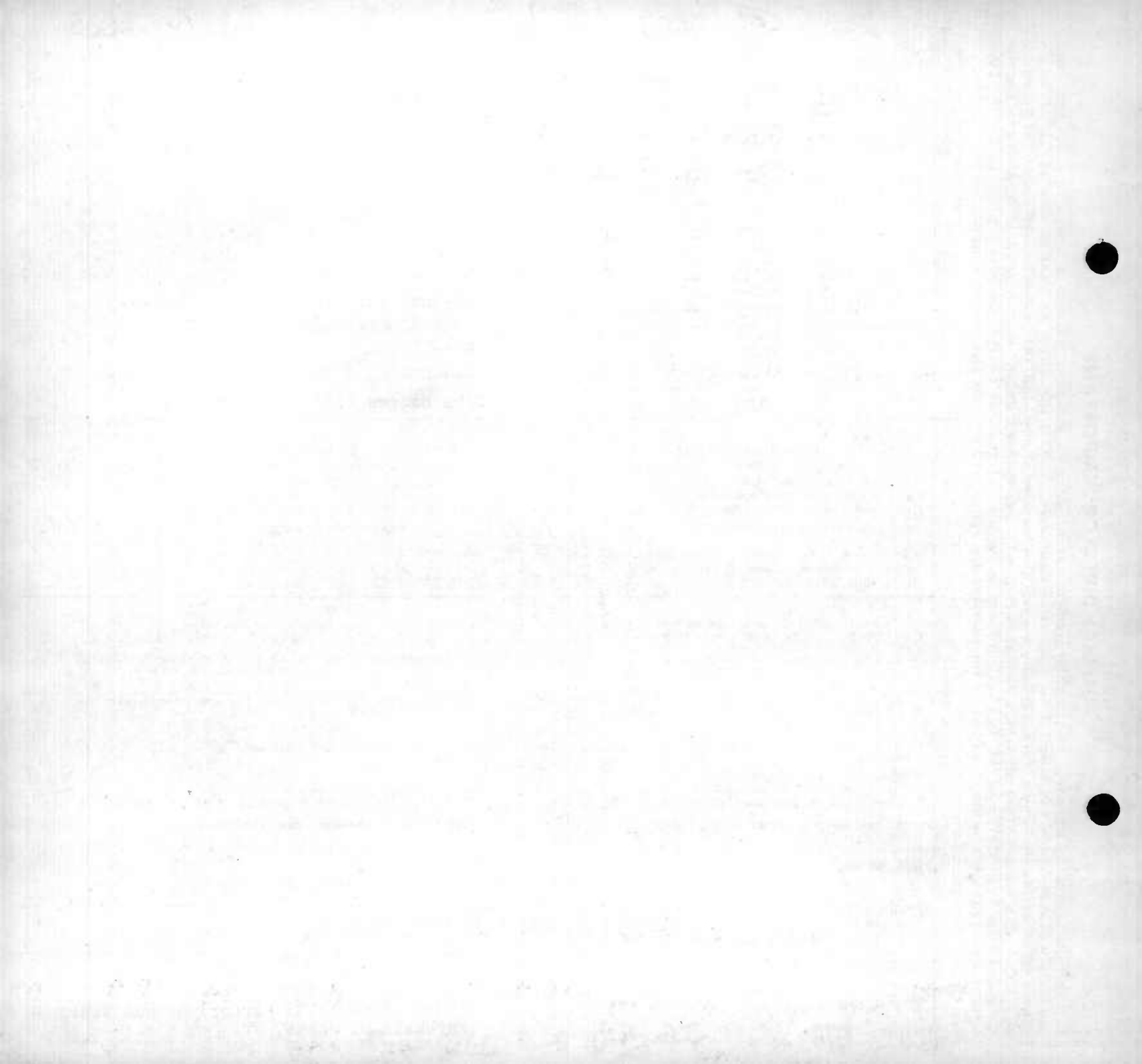
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5604</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>ALEAN B. PHILLIPS</u> <i>Alean B. Phillips</i>		<b>2. DATE AND HOUR OF DEATH</b> <u>5-30-70</u> <u>15:15</u> <u>PM</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Univ. of Maryland Hospital</u> <u>38</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1547</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>3004 Clifton Ave</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-6-99</u>	<b>9. AGE</b> (In years last birthday) <u>70</u>	<b>10. Under 1 Yr.</b> Months: <u>  </u> Days: <u>  </u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>		<b>13. FATHER'S NAME</b> <u>Walter Davis</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>243644917</u>		<b>17. INFORMANT</b> <u>3306 N. Hilton St. Apt. 3B</u> <u>Lillie Coleman (Daughter)</u> <u>Same</u>			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>(A) IMMEDIATE CAUSE</b> <u>Upper GI hemorrhage - shock</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <u>Stress ulcer (?)</u> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <u>Cerebrovascular accident</u> <b>(C)</b> <u>Aneurism of ascending aorta</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hrs</u> <u>?</u> <u>26 days</u> <u>?</u>
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>—</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes No</u>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>NO</u>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (H) (this hospital) attended the deceased from <u>May 5</u> 19<u>70</u> to <u>May 30</u> 19<u>70</u> that (H) (we) last saw the deceased alive on <u>May 29</u> 19<u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Paul R. Spielberg M.D.</u>				<b>23B. DATE SIGNED</b> <u>5-30-70</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type)				<b>23D. ADDRESS</b>	
<b>DEGREE</b>					
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>transit-burial</u>		<b>24B. DATE</b> <u>6-6-70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Provident Church Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Wise, N.C.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 2 1970</u>			
<b>25B. NAME OF REGISTRAR</b> <u>E. Taylor, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>735 Harford Av. 21225</u> <u>Marshall W. Jones, Jr.</u>			



# FUNERAL DIRECTOR: IMPORTANT

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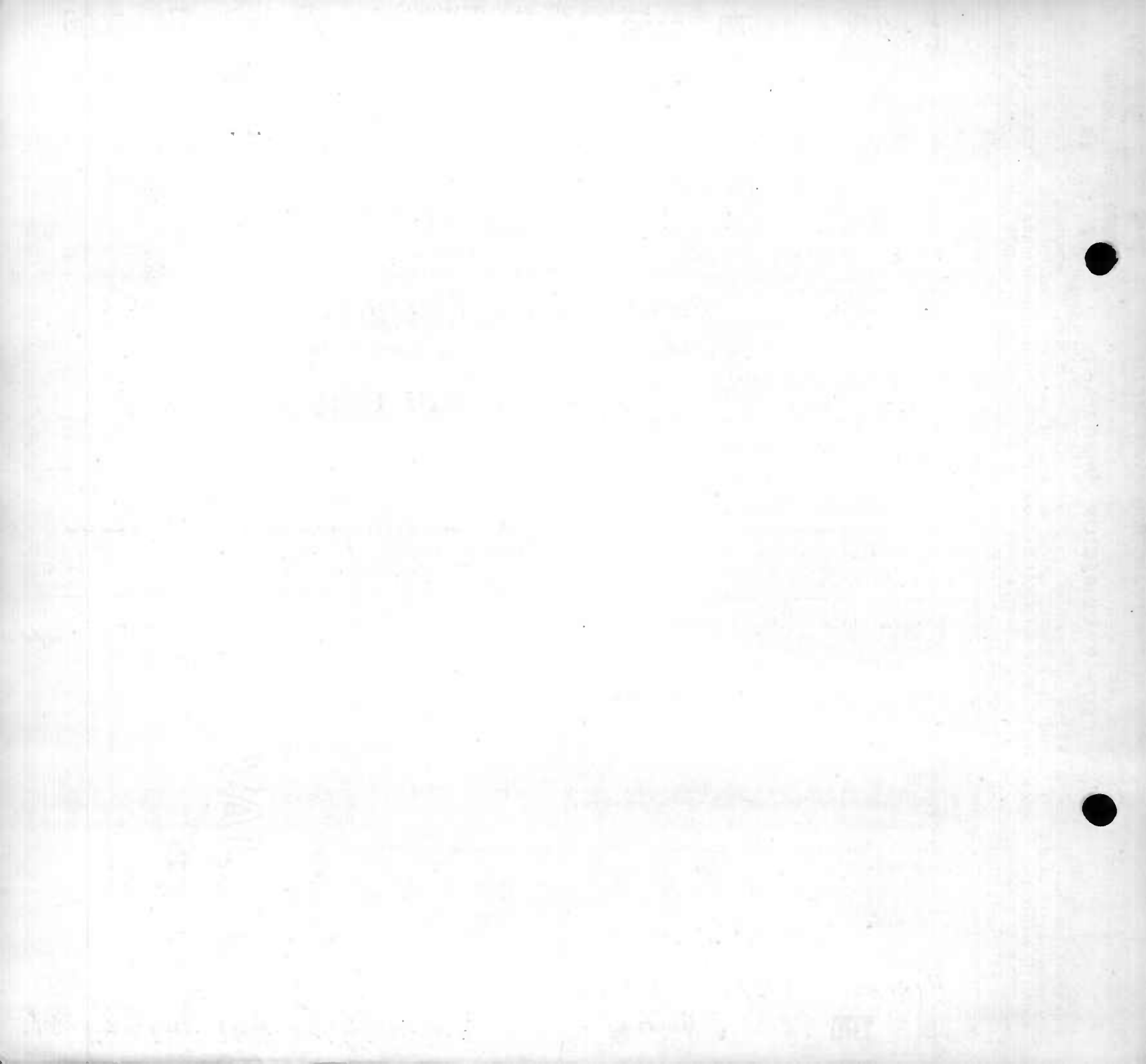
H-322 70 5605		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5605	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) (DARCUS) DOROTHY (HARDGE) HODGES		2. DATE AND HOUR OF DEATH 6-1-70 7:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 00 1828 East 32nd Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1828 East 32nd Street		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-00	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT John Hodges 1013 Sommerset St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESP ARREST (B) TERMINAL CA OF ORAL CAUTY DUE TO, OR AS A CONSEQUENCE OF: CA, BREAST (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2-5 YRS. 10 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 1970 to MAY 1970, that (I) (we) lost the deceased on MAY 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. ANDREW CHEN		23B. DATE SIGNED 6/1/70		23C. PHYSICIAN'S NAME (Type) J. C. ANDREW CHEN	
23D. ADDRESS John's Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-4-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 1735 Harford Avenue Marshall W. Jones, Jr.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 70 5606	
B-626 70 5606											
1. NAME OF DECEASED (Type or Print) <b>John Burggraf</b>											
2. DATE AND HOUR OF DEATH <b>5/30/70 8:32 P.M.</b>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.</b>					
<b>33 THE JOHNS HOPKINS HOSPITAL</b>						C. CITY OR TOWN <b>ARNOLD</b>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						E. STREET AND NUMBER <b>ROUTE 1 BOX 461</b>					
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-6-17</b>		9. AGE (In years last birthday) <b>52</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL</b>				11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FREDERICK BURGGRAF</b>						14. MOTHER'S MAIDEN NAME <b>ELEANORE KNIERIN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-01-1048</b>		17. INFORMANT <b>JUNE K. BURGGRAF #4</b>				ADDRESS	
18. <b>201 X I</b> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hodgkin's disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>		
ANTECEDENT CAUSES						(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Klebsiella pneumonia</b>			<b>2 weeks</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) <b>UGI bleeding</b>			<b>24 hrs.</b>		
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						<b>Multifocal leukoencephalopathy 2 1/2 @ 3 days</b>					
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Edward R. Block M.D.</b> OEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward R. Block M.D.</b> OEGREE						23D. ADDRESS <b>Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>6/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN CEM.</b>				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>				25C. FUNERAL DIRECTOR <b>John M. Lythgoe</b> ADDRESS <b>Johns Hopkins Hospital, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.5em;">70 5607</span>	
BIRTH NO. <span style="font-size: 1.5em;">W-800 70 5607</span>				1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Kathy Ann Wise</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">May 30, 1970 7:50 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Allegany</span>		5100	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">US Public Health Service Hospital</span>				C. CITY OR TOWN <span style="font-size: 1.2em;">Cumberland</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">Route #1 Bowman's Addition</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Cauc</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Apr 13, 1961</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">9</span>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">student</span>
10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Raymond G. Wise</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Margaret Welsh</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">none</span>		17. INFORMANT <span style="font-size: 1.2em;">Hospital chart</span>		ADDRESS
18. <span style="font-size: 1.5em;">204.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">bacterial pneumonia</span> (B) <span style="font-size: 1.2em;">viral pneumonia</span> (C) <span style="font-size: 1.2em;">acute lymphocytic leukemia</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">days</span> <span style="font-size: 1.2em;">days</span> <span style="font-size: 1.2em;">2 years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>we</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 7 1968</span> to <span style="font-size: 1.2em;">May 30 1970</span> , that <del>we</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 30 1970</span> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) <del>not</del> view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Samuel P. Ward M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">May 30, 1970</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Samuel P. Ward M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">USPHS Hospital</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/2/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Hillcrest Burial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Cumberland Allegany Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 2 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jaden</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Silcox-Merritt Fun. Ser. 404 Decatur St. Cumberland, Md.</span>			





## FUNERAL DIRECTOR: IMPORTANT

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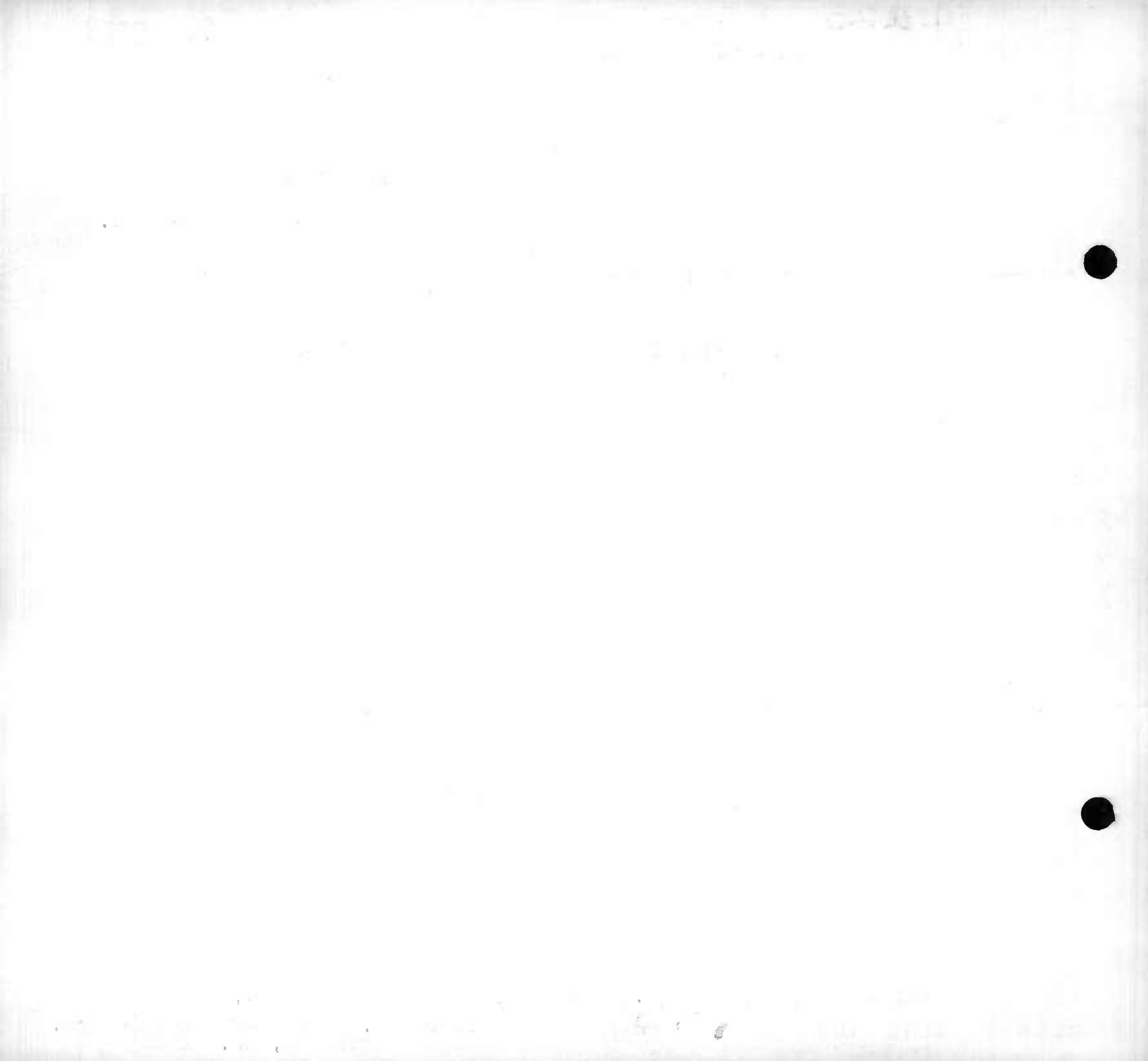
BIRTH NO. <u>J-525</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5608</u>					
1. NAME OF DECEASED (Type or Print) <u>WILLIAM V. JOHNSON</u>						2. DATE AND HOUR OF DEATH <u>5-29-70</u> <u>2:25 PM.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>						A. STATE <u>Maryland</u> B. COUNTY <u>2733</u>							
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <u>Baltimore</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
						E. STREET AND NUMBER <u>4940 Eastern Ave. 21224</u>			007				
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-18</u>		9. AGE (in years last birthday) <u>52</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Ellsworth D. Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Bertha Bromwell</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>4940 Eastern Ave.</u> <u>BCH Records: Baltimore, Md. 21224</u>			ADDRESS				
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable sepsis</u> <u>Diabetes Mellitus</u> (B) <u>Chronic typhloproctocolitis</u> (C) <u>R. Nephrolithiasis, probable polyp</u> <u>Osteomyelitis of lower extremities</u> <u>Severe Arthritis &amp; spinal ankylosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>37 yrs.</u>	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>													
19A. DATE OF OPERATION <u>5-24-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHRONIC TYMPANOMASTOIDITIS</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>5-26-69</u> 19 <u>70</u> to <u>5-29</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>5-29</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Jaime F. Casellas</u> DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5-29-70</u>				
23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLAS</u> DEGREE						23D. ADDRESS <u>Baltimore City Hospitals</u> <u>B. C. H. 4940 Eastern Ave.</u> <u>21224</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-2-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, JR.</u>		25C. FUNERAL DIRECTOR <u>CHARLES F. EVANS &amp; Son</u>		ADDRESS <u>8802 Harford Rd</u>							

4700 Harford Rd.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. <u>70 5609</u>	
BIRTH NO. <u>A-223 70 5609</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ALEXANDER AUGUSTYNIAK</u>		2. DATE AND HOUR OF DEATH <u>5/27/70</u> <u>130 PM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital, Baltimore, Maryland.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>HA</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>XXXXXXX XXXXXX</u>		F. UPTON RD. <u>Upton Rd.</u>	
5. SEX <u>Male</u>	6. RACE <u>American white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-02</u>
9. AGE (in years last birthday) <u>67</u>		10. IF Under 1 Yr. Months   Days   Hours   Min. <u>67</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Self Employed farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balt. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Balt. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Martin Augustyniak</u>		14. MOTHER'S MAIDEN NAME <u>Mary Chiehocik</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-52-8179A</u>	
17. INFORMANT <u>Brother WALTER August</u>		ADDRESS <u>8 Feranne Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Pneumonia</u>	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Scleroderma, dysphagia</u>	
		(C) <u>Cachexia</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Mal nutrition due to dysphagia</u>	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>will be done</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/5/70</u> 19 <u>70</u> to <u>5/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Wassif</u>		23B. DATE SIGNED <u>5/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. M. WASSIF M.D.</u>		23D. ADDRESS <u>South Balt. General Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>5/30/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Vaberg</u>	25C. FUNERAL DIRECTOR <u>George J. Gonce</u>	ADDRESS <u>4001 Ritchie Hwy. Baltimore, Md. 21225</u>



# FUNERAL DIRECTOR: IMPORTANT

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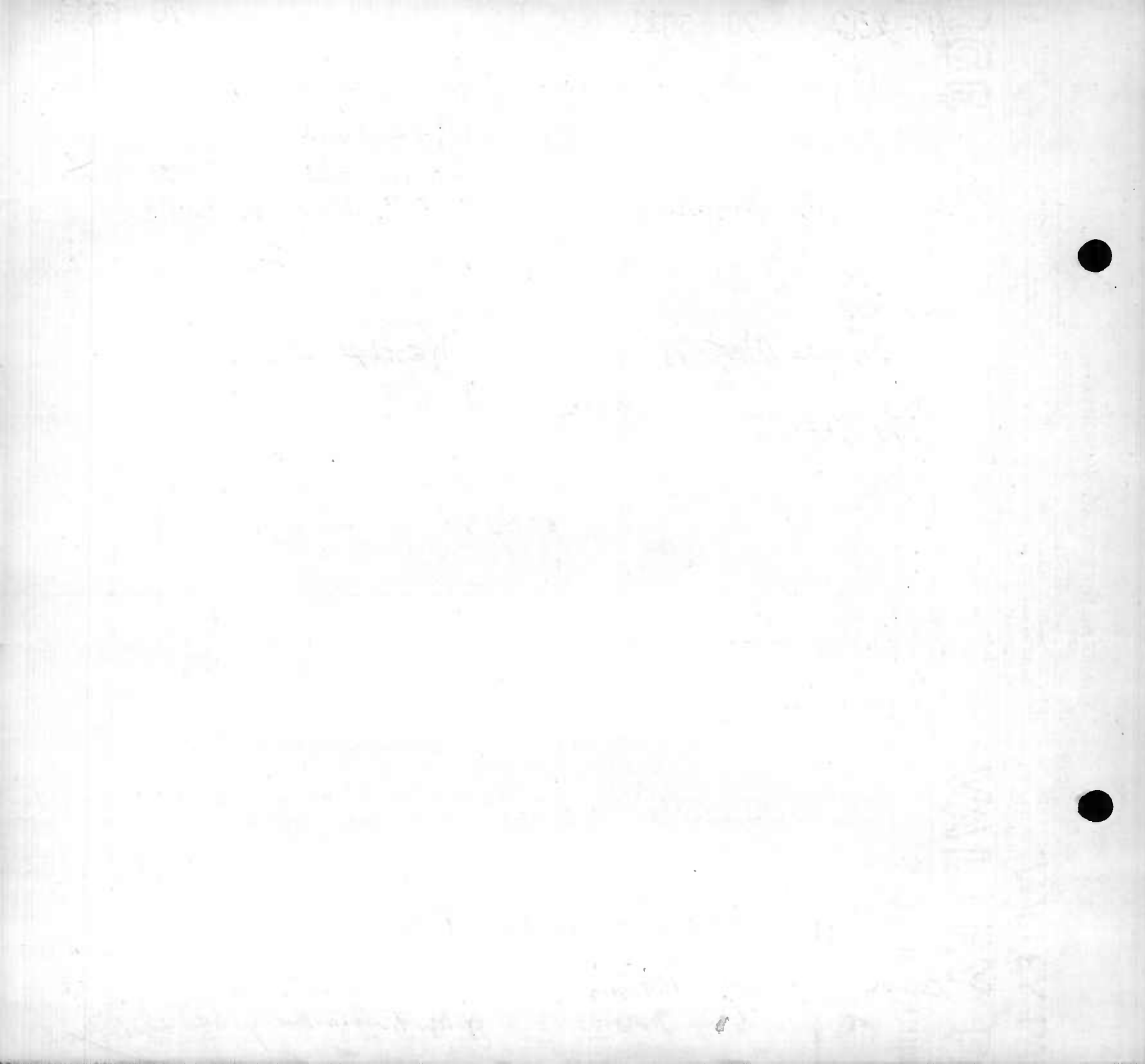
<h2 style="margin: 0;">S-220</h2>		<h2 style="margin: 0;">Baltimore City Health Department</h2>	
<h3 style="margin: 0;">BIRTH NO. JAN 1970</h3>		<h3 style="margin: 0;">REG. NO. 70 5610</h3>	
<b>1. NAME OF DECEASED</b> (Type or Print)		<b>2. DATE AND HOUR OF DEATH</b>	
<h2 style="margin: 0;">JAN SUCHOCKI</h2>		<h2 style="margin: 0;">5/28/1970 8:50 AM</h2>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
<h2 style="margin: 0;">South Baltimore general Hospital</h2>		<h2 style="margin: 0;">Maryland AA</h2>	
<b>5. SEX</b>		<b>6. RACE</b>	
<h2 style="margin: 0;">male</h2>		<h2 style="margin: 0;">American white</h2>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b>	
<b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<h2 style="margin: 0;">5-14-07</h2>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (State or foreign country)	
<h2 style="margin: 0;">Carpenter</h2>		<h2 style="margin: 0;">America Poland</h2>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<h2 style="margin: 0;">Andrew Suchocki</h2>		<h2 style="margin: 0;">Frances Jakubanis</h2>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<h2 style="margin: 0;">No</h2>		<h2 style="margin: 0;">213-32-7328</h2>	
<b>17. INFORMANT</b>		<b>ADDRESS</b>	
<h2 style="margin: 0;">His wife, Leokadia Suchocki</h2>		<h2 style="margin: 0;">Same</h2>	
<b>18. CAUSE OF DEATH</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>		<h2 style="margin: 0;">6 M.</h2>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<b>(A) IMMEDIATE CAUSE</b>	
<b>ANTECEDENT CAUSES</b>		<h2 style="margin: 0;">Malnutrition &amp; debility</h2>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(B) advanced Cancer stomach</b>	
<b>II</b>		<b>(C)</b>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	
<h2 style="margin: 0;">2/26/70</h2>		<h2 style="margin: 0;">advanced Cancer stomach</h2>	
<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<h2 style="margin: 0;">will be done</h2>		<h2 style="margin: 0;">No</h2>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<h2 style="margin: 0;">X</h2>		<h2 style="margin: 0;">A</h2>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b>	
<h2 style="margin: 0;">X</h2>		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
<b>21F. HOW DID INJURY OCCUR?</b>			
<h2 style="margin: 0;">A</h2>			
<b>22. I certify that (I) (this hospital) attended the deceased from 5/26 1970 to 5/28 1970 that (I) (we) last saw the deceased alive on 5/27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE</b>		<b>23B. DATE SIGNED</b>	
<h2 style="margin: 0;">Wassif</h2>		<h2 style="margin: 0;">5/28/70</h2>	
<b>23C. PHYSICIAN'S NAME</b> (Type)		<b>23D. ADDRESS</b>	
<h2 style="margin: 0;">Dr. WASSIF, M.D.</h2>		<h2 style="margin: 0;">South Baltimore general Hospital</h2>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>	
<h2 style="margin: 0;">Burial</h2>		<h2 style="margin: 0;">6/1/70</h2>	
<b>24C. NAME OF CEMETERY or CREMATORY</b>		<b>24D. LOCATION</b> (City, town, or county) (State)	
<h2 style="margin: 0;">Holy Cross</h2>		<h2 style="margin: 0;">Baltimore, Md.</h2>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>	
<h2 style="margin: 0;">JUN 2 1970</h2>		<h2 style="margin: 0;">Robert E. Taylor</h2>	
<b>25C. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<h2 style="margin: 0;">George J. Gonce</h2>		<h2 style="margin: 0;">4001 Ritchie Hgy. Baltimore, Md. 21225</h2>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-252 70 5611		70 5611			
1. NAME OF DECEASED (Type or Print) <b>Meekins, Benjamin</b>		2. DATE AND HOUR OF DEATH <b>5-29-70 10<sup>05</sup> A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Lutheran Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		E. STREET AND NUMBER <b>1940 Featherbed Lane</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-77</b>	9. AGE (In years lost birthday) <b>92</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joshua Meekins</b>		14. MOTHER'S MAIDEN NAME <b>KEZIAH Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter - in-law.</b>	
18. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrhythmia.</b> (B) <b>ASCD.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>5/25/70</b> to <b>5/29/70</b> that (I) (we) last saw the deceased alive on <b>5/29/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>K. Lwin</b>		23B. DATE SIGNED <b>5/29/70</b>		23C. PHYSICIAN'S NAME (Type) <b>KYI KYI LWIN</b>	
23D. ADDRESS <b>Lutheran Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>6-1-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT Olive</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE CO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970</b>		25B. NAME OF REGISTRAR <b>John T. Spurnberg</b>		25C. FUNERAL DIRECTOR <b>6411</b>	

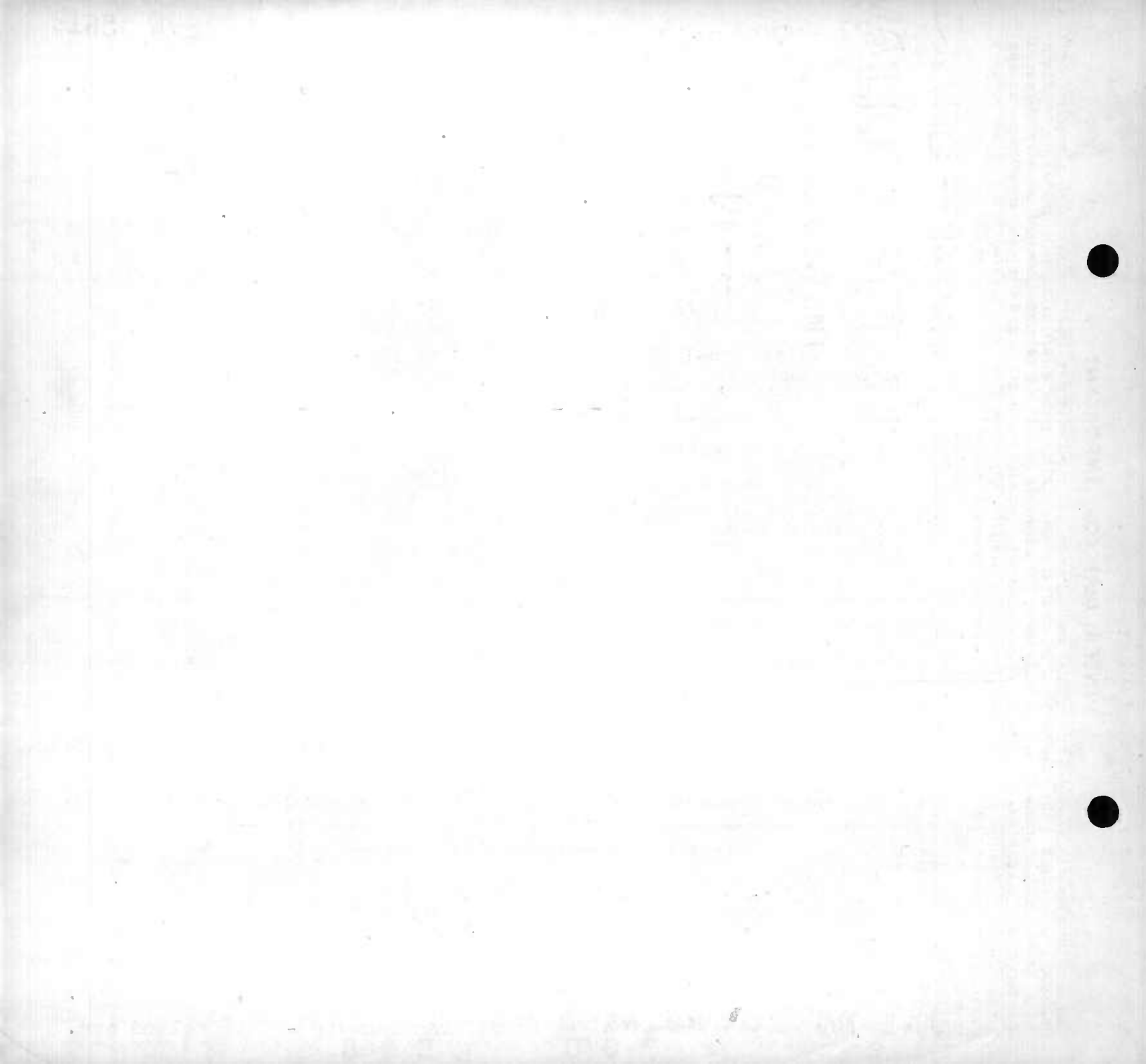




**FUNERAL DIRECTOR: IMPORTANT**

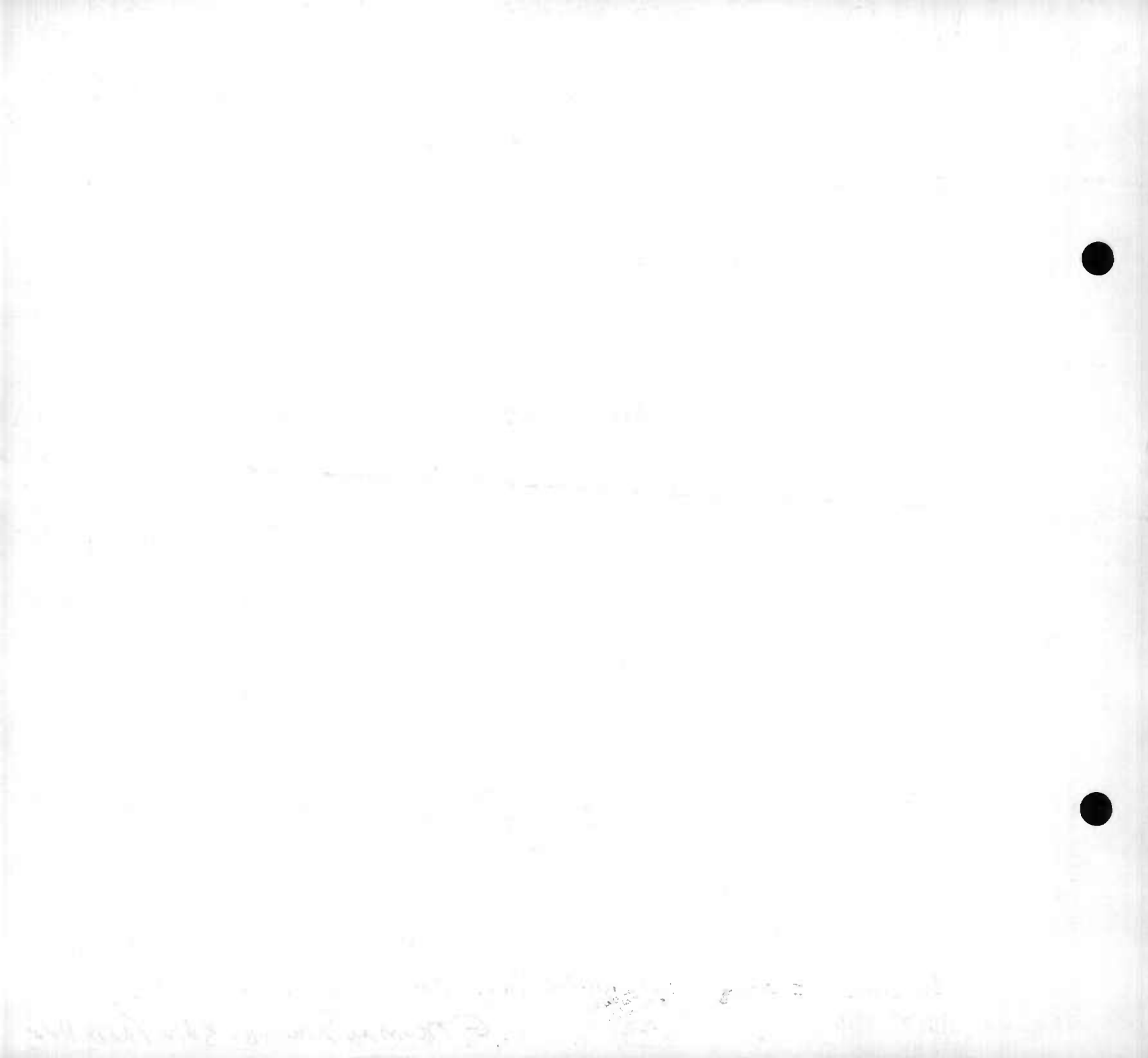
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400 70 5612				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5612	
1. NAME OF DECEASED (Type or Print) <b>Charles P. Deuel</b>				2. DATE AND HOUR OF DEATH <b>May 30, 1970 6 A.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 (DOA) Union Memorial Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1274 Woodbourne Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/5/1909</b>		9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personnel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O &amp; C&amp;D RR.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Deuel</b>				14. MOTHER'S MAIDEN NAME <b>Cora Kidwell</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>718-16-7918</b>		17. INFORMANT ADDRESS <b>Edna M. Deuel -1274 Woodbourne Ave.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>410.0 I</b> <b>CAUSE OF DEATH</b> <b>Anterior Myocardial Infarction</b> <b>5 min</b> <b>Anterior Myocardial Infarction</b> <b>5 min</b> <b>Anterior Myocardial Infarction</b> <b>5 min</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 19 1970</b> to <b>April 30 1970</b> , that (I) (we) last saw the deceased alive on <b>April 30 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Samuel O'Mansky M.D.</b>				23B. DATE SIGNED <b>June 1 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL O'MANSKY</b>				23D. ADDRESS <b>1523 2nd Avenue Blvd 2104.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Green Mount Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 2 1970 Robert E. Talbot, M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Ann Donovan - 3818 Roland Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-210		70 5614		BALTIMORE CITY HEALTH DEPARTMENT		X		70 5614	
BIRTH NO.		70 5614		CERTIFICATE OF DEATH		REG. NO.		70 5614	
1. NAME OF DECEASED (Type or Print) <i>Bishop, Lillian</i>				2. DATE AND HOUR OF DEATH <i>5-29-70 1215 A.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <i>BALTIMORE</i> B. COUNTY <i>5300</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 GRANADA NURSING HOME</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>4017 LIBERTY HEIGHTS AVE</i>		C. CITY OR TOWN <i>Essex</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <i>Box 338 E RIVERSIDE AV</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/25/85</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas Ford</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Gladys Brooks-338 E. Riverside</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CORONARY THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>GENERALIZED ARTERIO SCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>3/14/70</i> 19 to <i>5/29/70</i> 19 that (I) (we) last saw the deceased alive on <i>5/29/70</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (aid) (did not) view the body after death.									
23A. SIGNATURE <i>Lillian Bishop</i>				23B. DATE SIGNED <i>5/29/70</i>					
23C. PHYSICIAN'S NAME (Type) <i>HOLLIS SEUNARINE, M.D.</i>		23D. ADDRESS <i>1801 Greenbury Rd Mt.</i>		23E. DEGREE <i>M.D.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 31</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel</i>		24D. LOCATION City, town, or county (State) <i>Rock Hall Kent Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wesley R. Kane - Church Hill Ind.</i>		ADDRESS			



## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5615</u>	
X-000 70 5615		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Kiah Baby Boy Maxine</u>		2. DATE AND HOUR OF DEATH <u>5/20/70</u> <u>10:09</u> a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2634</u>			
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>6034 Amberwood Road Apt. B-4</u> <u>21206</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-70</u>	9. AGE (in years last birthday) <u>NB</u>	10. Under 1 Yr. Months Days <u>4</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Arthur Kiah</u>		14. MOTHER'S MAIDEN NAME <u>Maxine Geneva Ross</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records Baltimore, Maryland 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>cardiorespiratory</u> <u>anest</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>anemia, hyperbilirubinemia, prematurity</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 0 (Day) 1 (Year) 0 (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> 19 <u>70</u> to <u>5/20</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/20</u> 19 <u>70</u> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Dale Henken MD</u>				23B. DATE SIGNED <u>5/20/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Dale Henken</u>		23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>21224 Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>5-26-70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> <u>21224</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	

8/10/30 - Cause of Death  
Cong. Triplasmiasis  
Letter from PCH in file  
Bur. of Bvt - Am. Bldg.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5616</u>	
BIRTH NO. <u>M-245 70 5616</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>McCLAIN BABY BOY MAXINE</u>		2. DATE AND HOUR OF DEATH <u>5-25-70</u> <u>11:25</u> PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4940 Eastern Avenue Baltimore, Maryland</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2506</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>3432 Chessell Court 21226</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-70</u>	9. AGE (In years last birthday) <u>NB</u>	10. If Under 1 Yr. Months: Days: Hours: Min. <u>2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Maxine Jane McClain</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records Baltimore, Maryland 21224</u>	
18. <u>226.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>asphyxia neonatorum 2 hr</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>5/25</u> 19 <u>70</u> to <u>5/25</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>5/25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dale P. Henken MD</u>		23B. DATE SIGNED <u>5/26/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dale P. HENKEN MD</u>		23D. ADDRESS <u>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Balt. Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>5-27-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21224</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

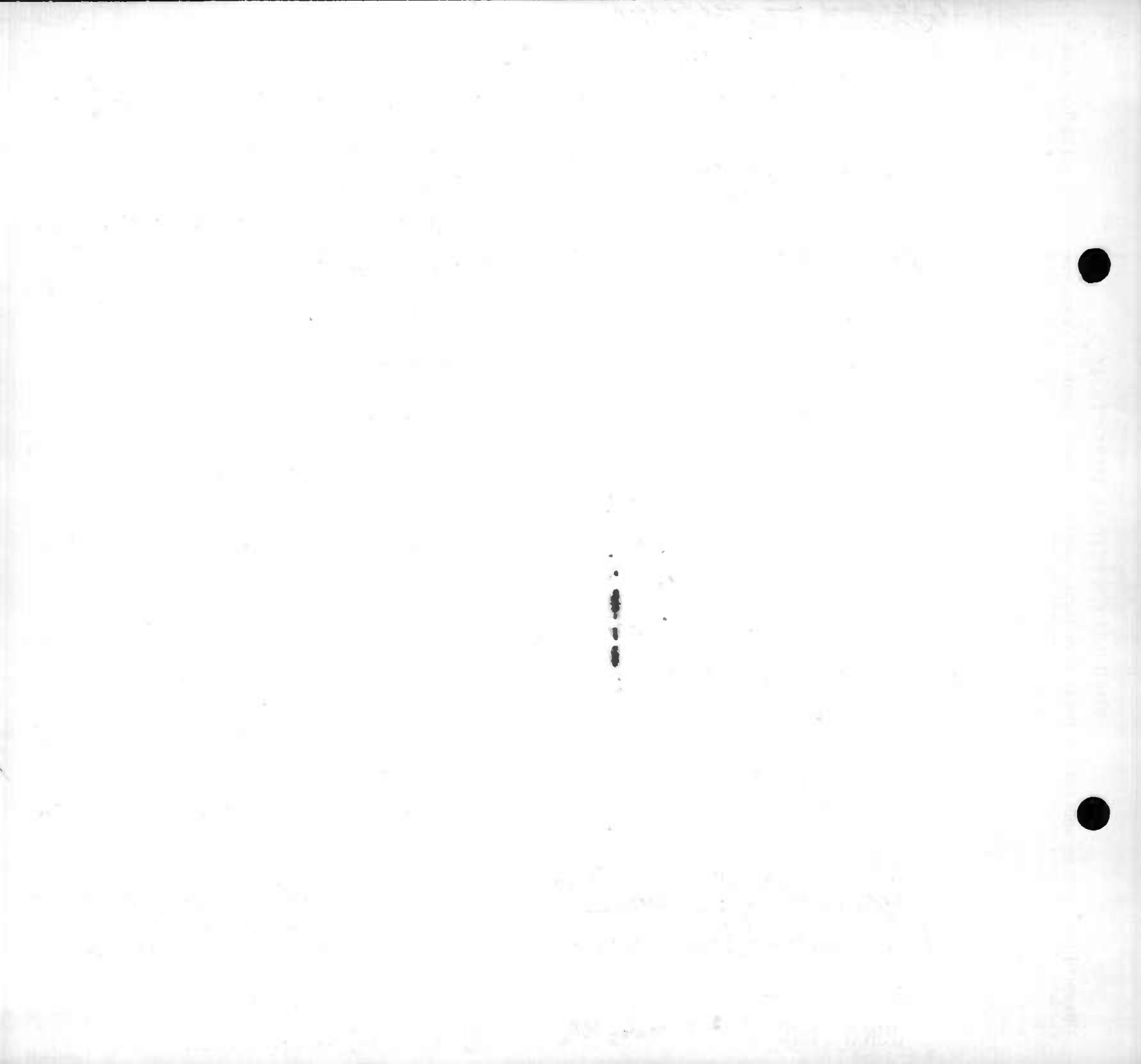
BIRTH NO. 11-26370 5617				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5617	
1. NAME OF DECEASED (Type or Print) MC CARTY BABY GIRL				2. DATE AND HOUR OF DEATH 5-28-70		1:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 1940 EASTERN AVE. BALTIMORE, MD. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 748 ALDORTH RD. 21222					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-70	9. AGE (In years last birthday) 2	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WAYNE				14. MOTHER'S MAIDEN NAME JOANNE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT BCH RECORDS: 1940 EASTERN AVE. ADDRESS BALTIMORE, MD. 21224			
18. 776-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>respiratory distress 2 days</i> (B) <i>prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: <i>2 days</i> (C) <i>cardiorespiratory arrest</i> Immed				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-26-1970 to 5-28-1970 that (I) (we) last saw the deceased alive on 5-28-1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE * Dale P. Henken MD				23B. DATE SIGNED 5-28-70					
23C. PHYSICIAN'S NAME (Type) DR. DALE P. HENKEN MD				23D. ADDRESS BALTIMORE CITY HOSPITALS 1940 EASTERN AVE. 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 5-28-70		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224			
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL HOME HOSPITAL DISPOSAL		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 5618	
BIRTH NO. 70 5618		1. NAME OF DECEASED (Type or Print) <b>MARCUS CORCORAN</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>6-1-70 12:50 A.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MONTEBELLO STATE HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
91		E. STREET AND NUMBER <b>1745 WILKENS AVE-21223</b>			
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-06</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>U.S., Mass.</b>	
13. FATHER'S NAME <b>Michael Corcoran</b>		14. MOTHER'S MAIDEN NAME <b>Sarah -</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>212 46 9842</b>		17. INFORMANT ADDRESS <b>Hospital Records</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL HEMORRHAGE</b>		<b>5 DAYS.</b>	
ANTECEDENT CAUSES		(B) <b>ARTERIO SCLEROTIC</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>HYPERTENSIVE VASC. DISEASE</b>		<b>20+ YRS.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>3 FRACTURE RT. HIP.</b>		<b>2/27/70.</b>	
19A. DATE OF OPERATION <b>2-28-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FRACT. RT. HIP.</b>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME.</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1741 WILKENS AVE BALTO.</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>FEB. 27-70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>FALL AT HOME.</b>	
22. I certify that (If (this hospital) attended the deceased from <b>MAY 13</b> 19 <b>70</b> to <b>MAY/JUNE 1</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>JUNE 1</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raymond W. Herrmann</b>		23B. DATE SIGNED <b>June 1, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>RAYMOND W. HERRMANN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-4-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kennedy Inc 1600 H &amp; L</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 5619</b>	
BIRTH NO. <b>B-253 70 5619</b>					
1. NAME OF DECEASED (Type or Print) <b>OLLIE BESSANT</b>			2. DATE AND HOUR OF DEATH <b>5/30/70 5:50 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD</b> B. CITY <b>BALTO</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1602 Peach St. 71230</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-17-12</b>	9. AGE (in years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-26-2219 A</b>		17. INFORMANT <b>LEON BESSANT - SAME</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hemorrhage, mid brain</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive cardiovascular dis.</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes; Portal Cirrhosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>5/29/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>5/29/70</b> 19 <b>70</b> to <b>5/30</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>5/30</b> 19 <b>70</b> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward Sherrev Jr MD</b>			23B. DATE SIGNED <b>31 May 70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Edward Sherrev Jr MD</b>			23D. ADDRESS <b>So. Balt. Gen. Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>6-4-70</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>MT. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Balto, Md.</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Isaiah Brown + Son</b> ADDRESS <b>123 W. Montgomery</b>	

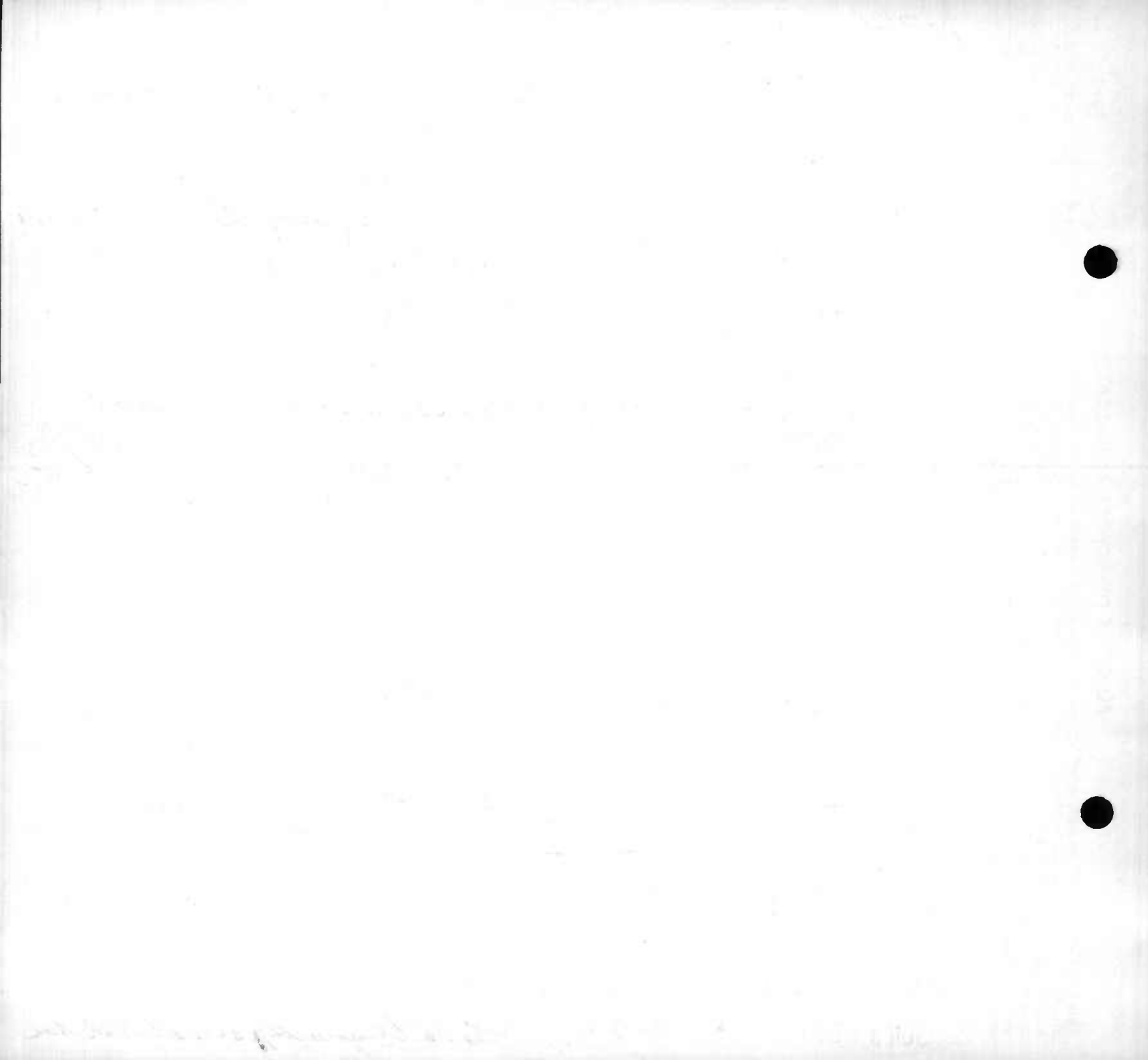




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

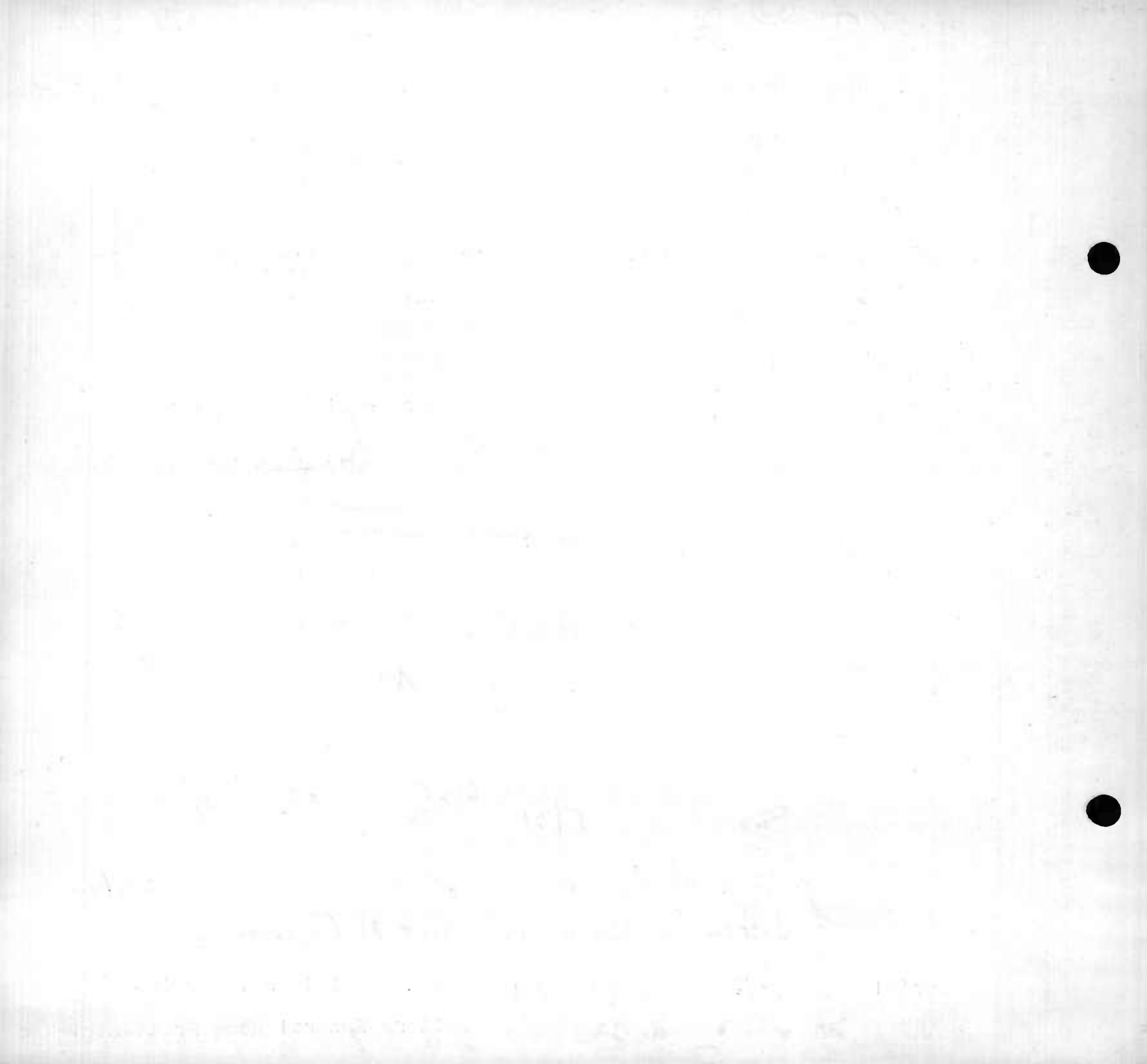
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. <u>70 5620</u>											
1. NAME OF DECEASED (Type or Print)		<u>KATHLEEN E. LUDWICK</u>				2. DATE AND HOUR OF DEATH <u>5/30/70 12 noon M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2714</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>						C. CITY OR TOWN <u>BALTO</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER <u>W. Coldspring Lane #1044</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/93</u>		9. AGE (In years last birthday) <u>76</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>ENTERTAINMENT</u>				11. BIRTHPLACE (State or foreign country) <u>SPRINGFIELD MO.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>085-61-0474</u>		17. INFORMANT <u>CHARLES G LUDWICK</u>			ADDRESS <u>SAME.</u>		
18. <u>485 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>											
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that <u>42</u> (this hospital) attended the deceased from <u>5/29/70</u> 19 to <u>5/30/70</u> 19 that <u>42</u> (we) last saw the deceased alive on <u>5/30/70</u> 19 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.											
23A. SIGNATURE <u>Donald D. Gaynor md</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5/30/70.</u>		
23C. PHYSICIAN'S NAME (Type) <u>DONALD D. GAYNOR</u>						23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-2-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE MEM. PK</u>		24D. LOCATION (City, town, or county) (State) <u>DORSEY MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u>		ADDRESS <u>3615 Bluebird Ave</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 70 5621				
L-560 70 5621														
BIRTH NO.														
1. NAME OF DECEASED (Type or Print) <b>MRS MARY P. LAHNER</b>					2. DATE AND HOUR OF DEATH <b>5/31/70 10:30 A.M.</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>MD</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Harbor View NCC</b>					C. CITY OR TOWN <b>Baltimore MD</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>									
E. STREET AND NUMBER														
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/1895</b>		9. AGE (In years last birthday) <b>74</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>														
13. FATHER'S NAME <b>James Brown</b>					14. MOTHER'S MAIDEN NAME <b>Madeline Thomas</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>217-38-2042</b>					17. INFORMANT <b>Harbor View NCC Records</b>				
18. <b>493 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Terminal Bronchial Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchial Asthma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>AS.C.V. Disease</b>														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>6/25</b> 19 <b>69</b> to <b>5/31</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>5/31</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Joseph S. Blum</b>					23B. DATE SIGNED <b>6/1/70</b>									
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM MD</b>					23D. ADDRESS <b>1115 N. CALVERT ST</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>6/3/70</b>					24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>				
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>														
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>Walters Funeral Home Pratt &amp; Stricker</b>				
25D. ADDRESS <b>815</b>														



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 5622		REG. NO. 70 5622	
BIRTH NO. <u>A-531</u>		70 5622		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DIMITRY ANTIPOROWICH</u> (ANTY)				2. DATE AND HOUR OF DEATH <u>May 28, 1970 5:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTH CHARLES GEN. HOSPITAL</u> <u>49</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u>		B. COUNTY <u>102</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3005 E. Baltimore St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-96</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Maryland Drydock</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>? unknown</u>				14. MOTHER'S MAIDEN NAME <u>? unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-03-2127</u>		17. INFORMANT <u>BERTHA ANTIPOROWICH</u>	
				ADDRESS <u>SAME</u>			
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma, Left Lung</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Renal Failure</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Renal Failure</u>							
19A. DATE OF OPERATION <u>5-19-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Neoplasm, Left lobe</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> 19 <u>70</u> to <u>May 28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>May 28</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. Canino - M.D.</u>				23B. DATE SIGNED <u>5-28-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. CANINO - M.D.</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/1/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Trinity Russian Orth.</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane</u>	

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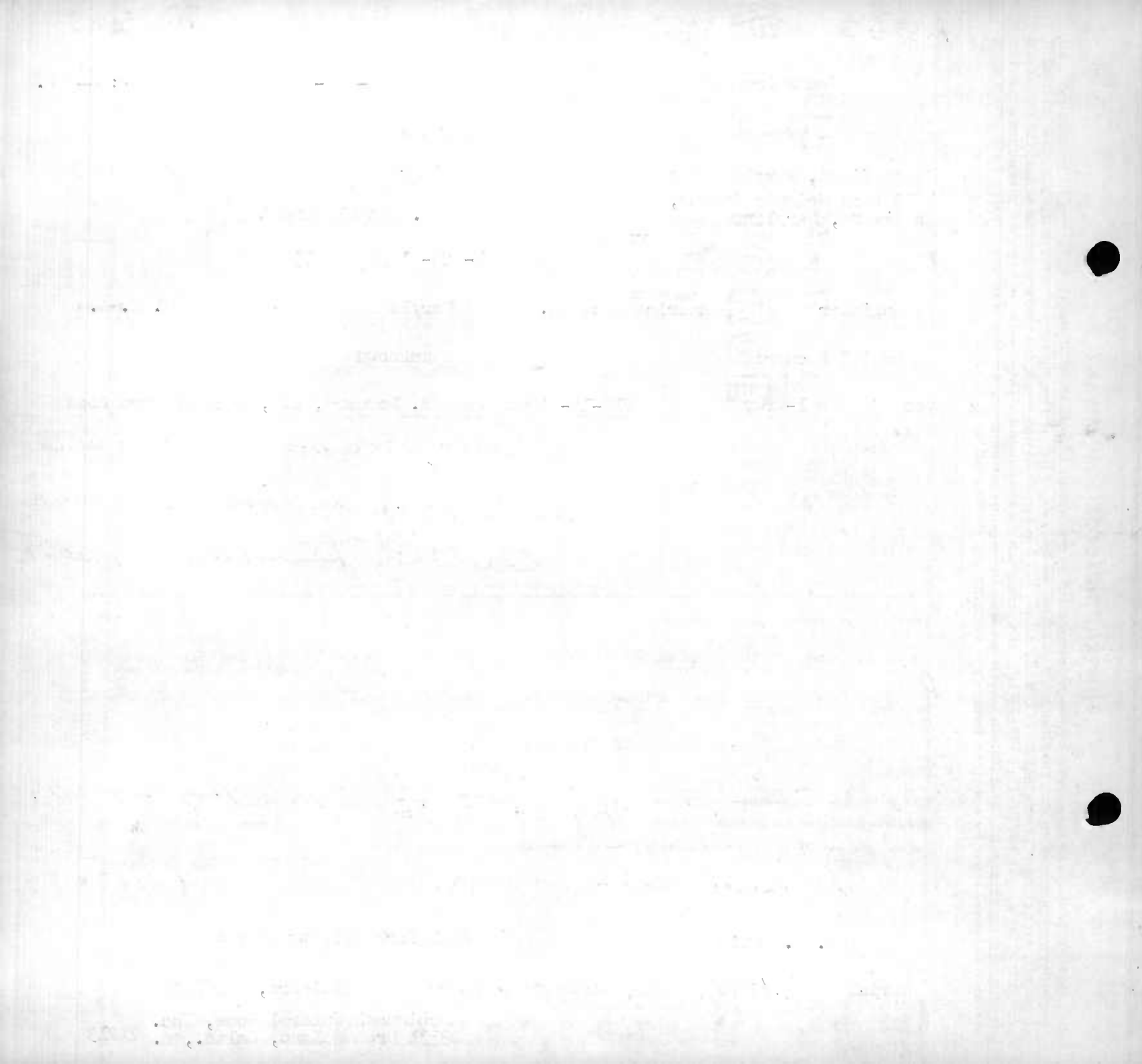
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5623</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">L-563</span> <span style="font-size: 1.5em;">70 5623</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Frank Leonard</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">5-29-70</span>   <span style="font-size: 1.2em;">12:05 P. M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Mount Siani, Nursing Home</span> <span style="font-size: 1.2em;">4613 Park Heights Avenue,</span> <span style="font-size: 1.2em;">Baltimore, Maryland</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">704</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">806 N. Chapel Street</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">7-24-1896</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">73</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Engineer</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">American Ice Co.</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S. A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Daniel Leonard</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">unknown</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes WW 1-Army</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-18-3306A</span>			<b>17. INFORMANT</b> <span style="font-size: 1.2em;">John S. Leonard, son, 1825 Weyburn Road</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Bronchopneumonia</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">acute myocardial infarction</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cerebral Thrombosis</span> (C) _____		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.2em;">none</span>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">3 days</span> <span style="font-size: 1.2em;">2 weeks</span> <span style="font-size: 1.2em;">1 week</span>		
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">no</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">May 26</span> <span style="font-size: 1.2em;">1970</span> to <span style="font-size: 1.2em;">May 29</span> <span style="font-size: 1.2em;">1970</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 29</span> <span style="font-size: 1.2em;">1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Daniel Levin</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6/1/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. M. Levin</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">6101 Park Heights Avenue</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6/2/70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 3 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">John E. ...</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span> <span style="font-size: 1.2em;">3332 Brehms Lane, Balto., Md. 21213</span>			

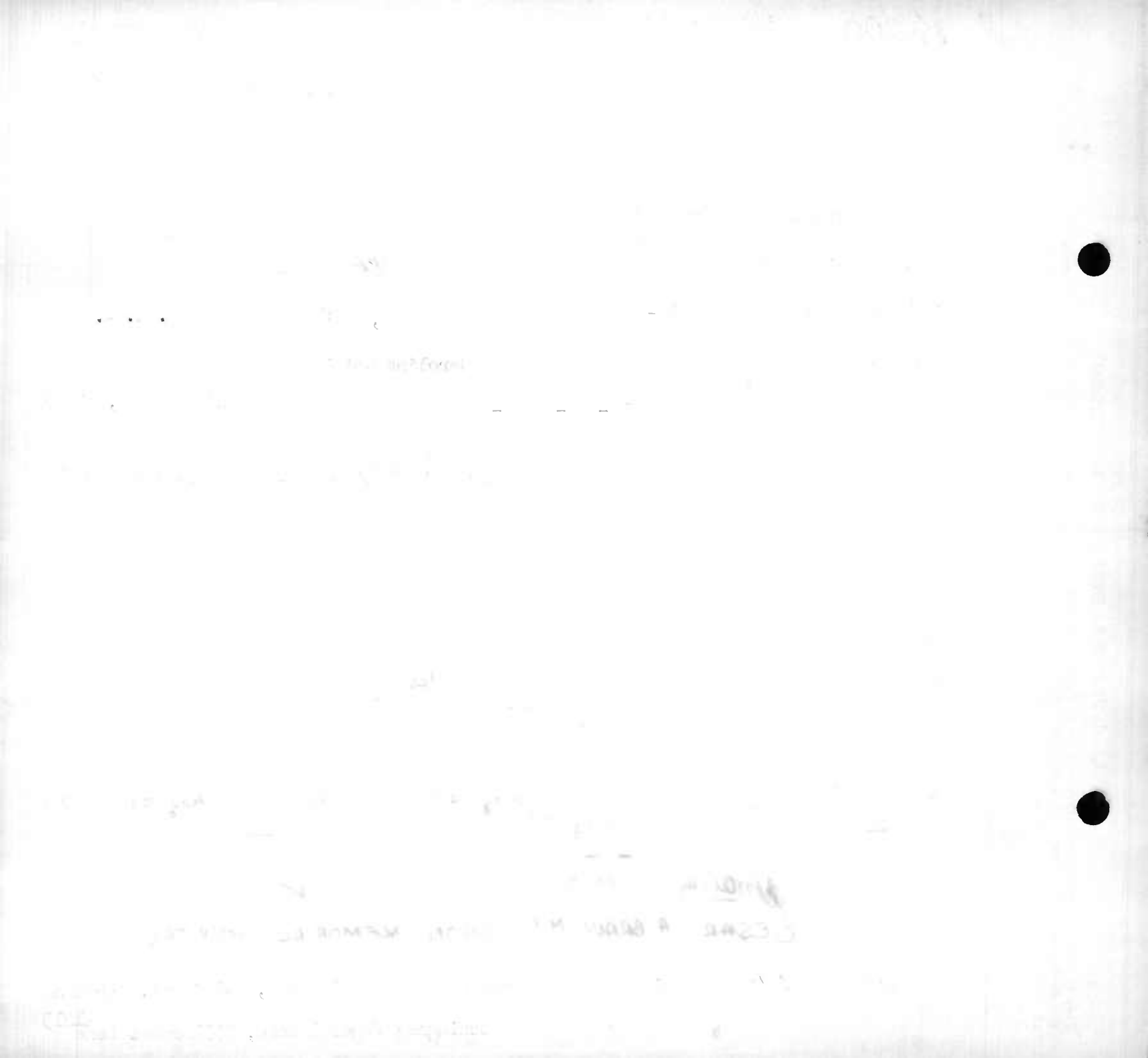




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

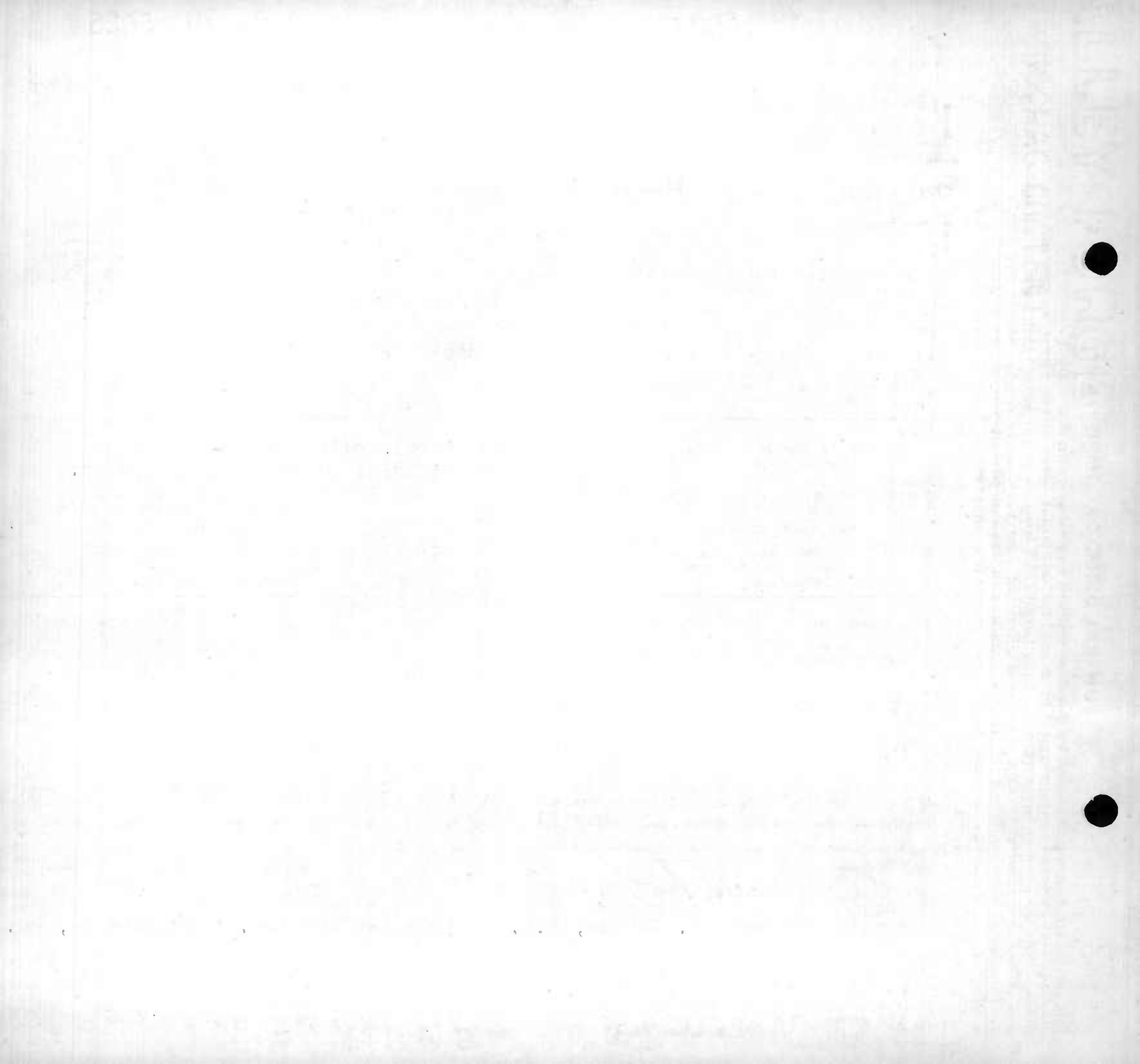
B-200 70 5624		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5624	
1. NAME OF DECEASED (Type or Print) <u>Matthew C. Rosso</u>		2. DATE AND HOUR OF DEATH <u>5-27-70</u> <u>9:58/A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3747 Bonview Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-05-96</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurateur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Italy Secily</u>	
13. FATHER'S NAME <u>MR. SEBASTIAN ROSSO</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Natale</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-8322</u>		17. INFORMANT <u>Mrs Catherine Rosso</u> ADDRESS <u>3747 Bonview Avenue, 21213</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 27</u> 19 <u>70</u> to <u>May 27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>May 27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar A. Bravo</u> M.D. DEGREE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>CESAR A. BRAVO M.D.</u> DEGREE	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>6/1/1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Belair Road, Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, 3331 Brehms Lane 21213</u>	



# FUNERAL DIRECTOR: IMPORTANT

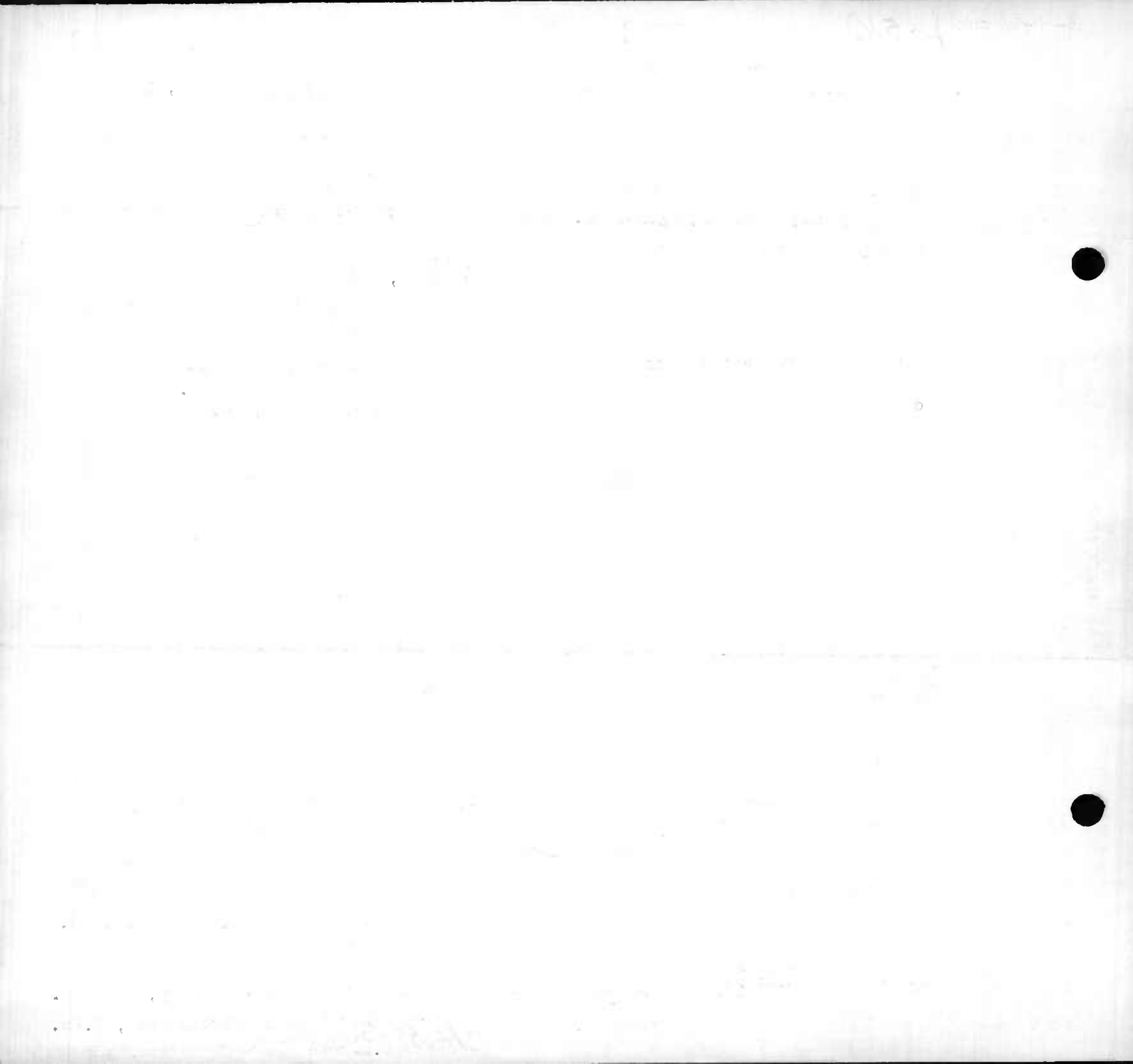
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 5625</span>	
<div style="display: flex; justify-content: space-between; font-size: 1.2em;"> <span>4-560 70 5625</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Margaret Louise Hamer</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">May 30, 1970 2:30 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">101</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">Baltimore City Hospital</span> <span style="font-size: 1.1em;">131</span>			C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.1em;">3132 Falt Ave.</span>		
5. SEX <span style="font-size: 1.1em;">F</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">3-23-1907</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">63</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Homemaker</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.1em;">Peter Muehlberger</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Louise Hertz</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">212-09-5271</span>		17. INFORMANT <span style="font-size: 1.1em;">George Hamer</span>
			ADDRESS <span style="font-size: 1.1em;">7502 Poplar Ave.</span>		
18. <span style="font-size: 1.2em;">412.4 I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Arteriosclerotic Cardio-vascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">March 5</span> 19 <span style="font-size: 1.1em;">70</span> to <span style="font-size: 1.1em;">May 30</span> 19 <span style="font-size: 1.1em;">70</span> , that (I) <del>was</del> last saw the deceased alive on <span style="font-size: 1.1em;">May 21</span> 19 <span style="font-size: 1.1em;">70</span> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Clarence W. LeDoux</span>				23B. DATE SIGNED <span style="font-size: 1.1em;">6/1/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Clarence W. LeDoux, M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">3023 Eastern Ave. Baltimore 24, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">6-2-70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Mt. Carmel</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">JUN 3 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Fisher</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">Thelma Hoffmann 3218 Hudson St</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 5626		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5626	
1. NAME OF DECEASED (Type or Print) <b>Glenda Mary Lamp</b> <b>LAMP, GLENDA Mary</b>				2. DATE AND HOUR OF DEATH <b>5/29/70 May 29, 1970 3:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BALTIMORE CITY HOSPITAL</b> <b>4940 Eastern Ave., Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ohio</b> B. COUNTY <b>Darke</b> C. CITY OR TOWN <b>Greenville</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>403 Central Avenue</b>			
5. SEX <b>Female</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/8/29</b> 9. AGE (in years lost birthday) <b>41</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>USA (West Virginia)</b>	
13. FATHER'S NAME <b>ORR, Boyd Raymond Orr</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Elizabeth Hess</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>None</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>4940 Eastern Ave.</b> ADDRESS <b>BCH Records: Baltimore, Md. 21224</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>197X I</b> <b>CEREBRAL EDEMA</b> <b>MULTIPLE METASTATIC MALIGNANT TUMOR</b> <b>None</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 da</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>3/5/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MALIGNANT BRAIN TUMOR</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>None</b>		21E. INJURY OCCURRED <b>None</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>			
22. I certify that (I) (the hospital) attended the deceased from <b>5/25/70</b> 19 <b>70</b> to <b>5/29/70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>5/25/70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>5/29/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>BRUCE NORTON</b>				23D. ADDRESS <b>4940 Eastern Ave. Baltimore, Md. BALTO. CITY HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 2 May 1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Trinity Lutheran Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Rural Berkeley County, West Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Brown Funeral Home</b>		25D. ADDRESS <b>Martinsburg, W. Va.</b>	



BALTIMORE CITY HEALTH DEPARTMENT				70 5627			
W-410 70 5627				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Robert B Wolf				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 1 70 3:50 p M.			
6. SEX male				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102			
7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan 15 1904		10. AGE (In years last birthday) 66		E. STREET AND NUMBER 529 N. Howard St.			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Raphael			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mollie			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 215-14-1847		18. INFORMANT ADDRESS Mr. Ted Wolf 430 S. Pelash St			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic emphysema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/2/70							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 3, 1970		24C. NAME OF CEMETERY or CREMATORY Oke Knesseth Land		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Sylvan Lewis & Son		ADDRESS 9610 Reisterstown Rd	

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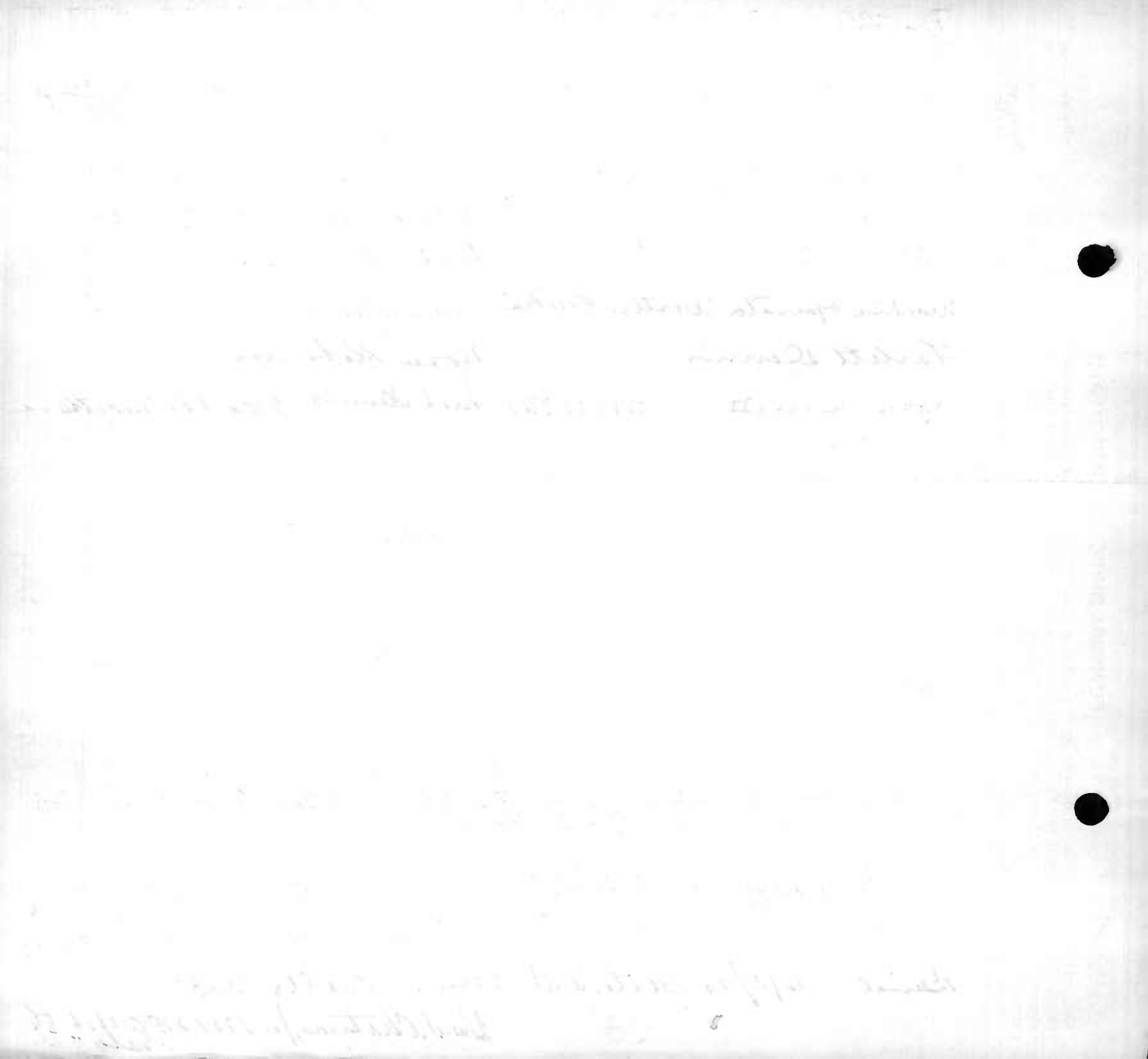
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

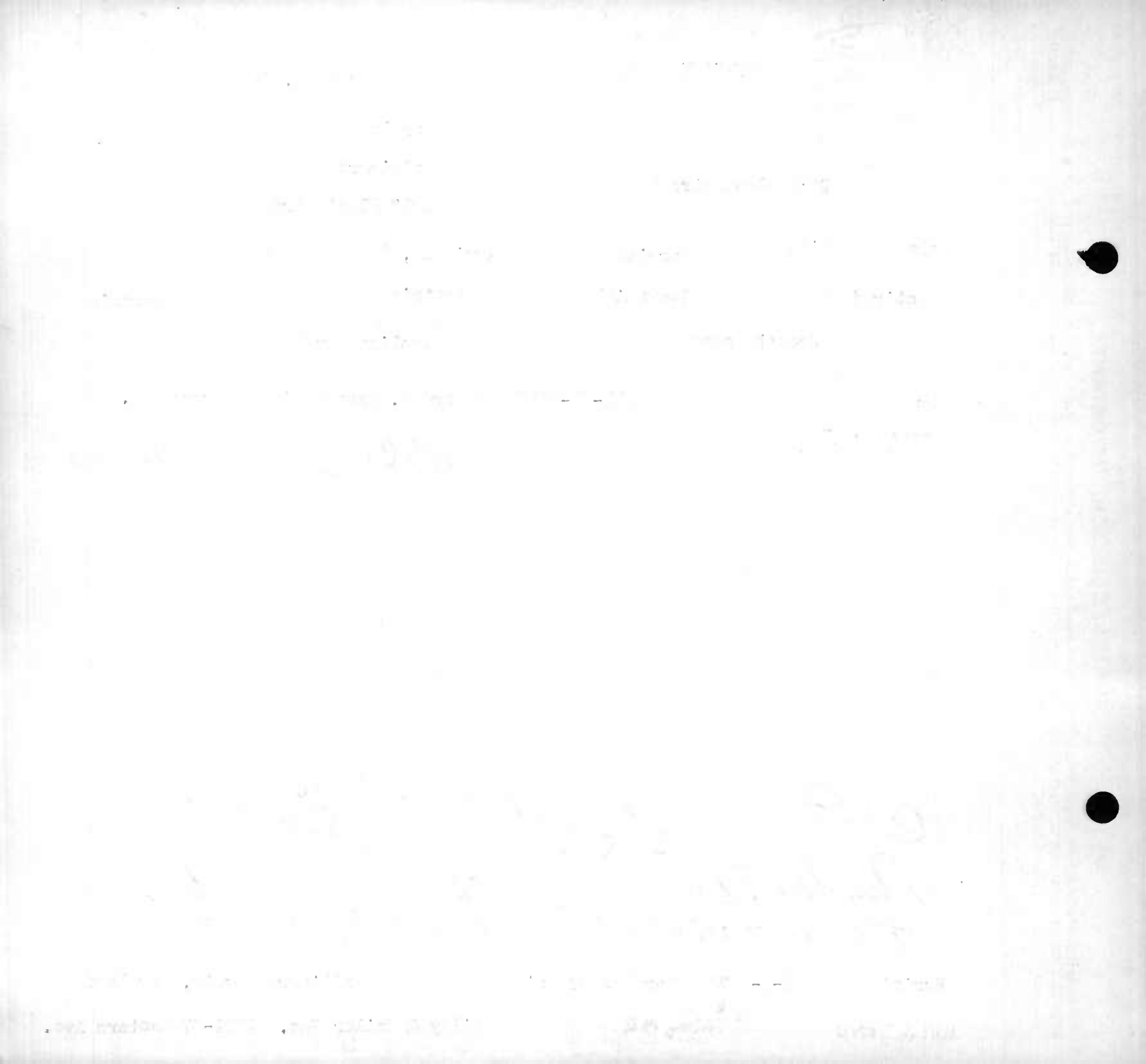
D-520 70 5628		BALTIMORE CITY HEALTH DEPARTMENT		70 5628	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Dennis, Vernon</i>			2. DATE AND HOUR OF DEATH <i>6-1-70 11:00 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2710</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Baltimore</i> <i>42</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>5306 Kenilworth Ave.</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-27-20</i>	9. AGE (In years last birthday) <i>49</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Farlett Dennis</i>			14. MOTHER'S MAIDEN NAME <i>Rosie Robinson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes w.w.ii</i>		16. SOCIAL SECURITY NO. <i>219-01-9703</i>		17. INFORMANT <i>Carol Dennis</i> ADDRESS <i>5306 Kenilworth Ave.</i>	
18. <i>1977.8 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Carcinoma of the liver</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-30</i> 19 <i>70</i> to <i>6-1-70</i> and that (I) (we) last saw the deceased alive on <i>6-1-70</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Guadalupe T. Orellana</i>				23B. DATE SIGNED <i>6-1-70</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6/5/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balti. Nat. Cem.</i>	
24D. LOCATION <i>Balti. Md.</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 3 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Chatman</i> ADDRESS <i>1701 McCalister St. Baltimore</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

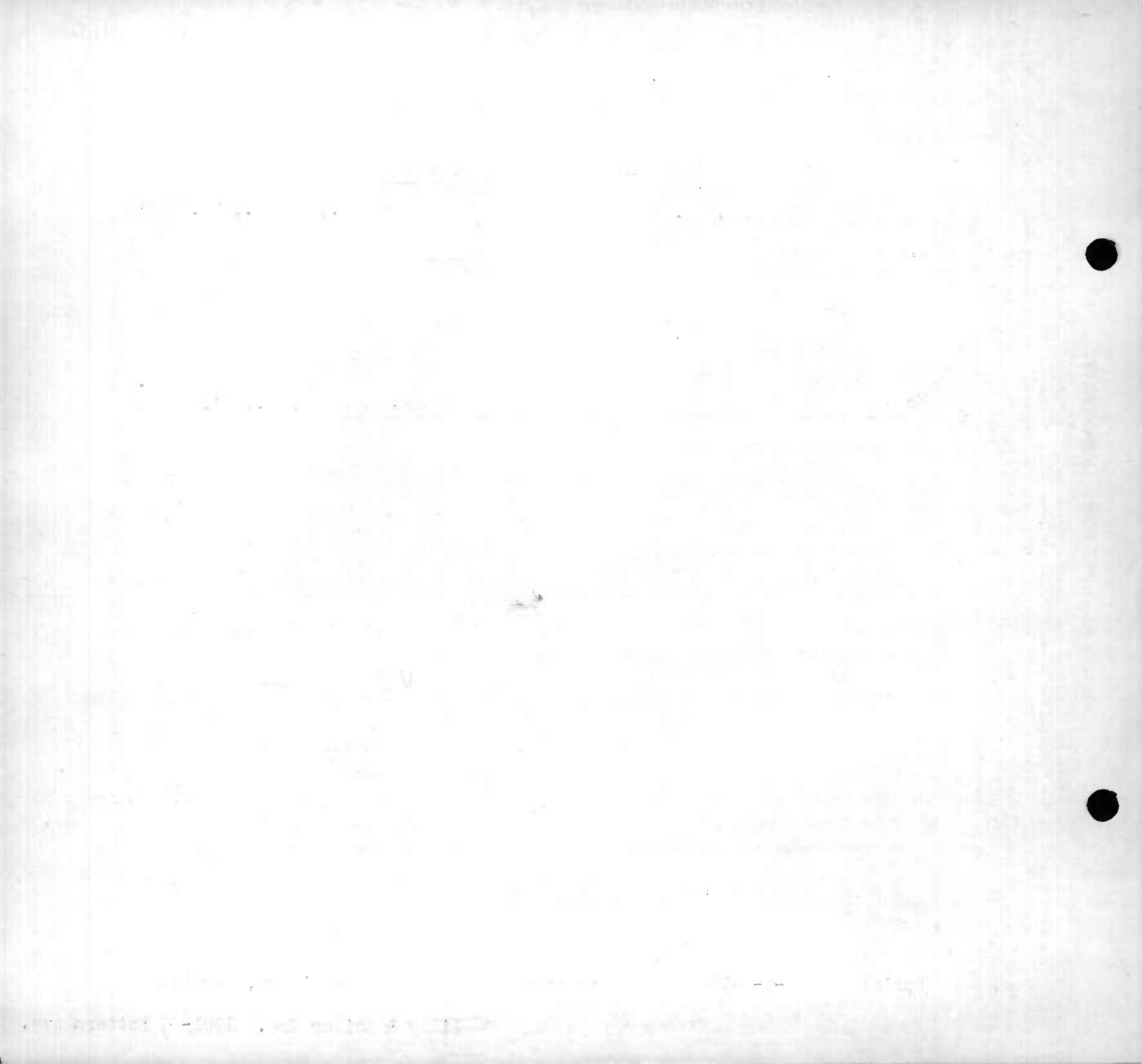
L-220 BIRTH NO.		70 5629		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 5629	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		M.	
STANLEY LASEK				June 2, 1970			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
00		2017 Fleet Street		Maryland		203	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2017 Fleet Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
Male	White	Married	April 28, 1886	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired		Blacksmith		Austria		Austria	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Lasek				Apolina Navak			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		214-03-1115		Edward F. Lasek		1629 Malvern St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
412.4 I				Gen. ASCVD		20 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 4 1970 to 6-2-70 1970, that (I) (we) lost saw the deceased alive on May 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Theodore T. Muzik M.D.				6-3-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. T. MIZNIK M.D.				429 S. Chester St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-5-1970		Gardens of Faith		Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 3 1970		Robert E. Fisher, M.D.		Lilly & Zeiler Inc.		1901-07 Eastern Ave.	



## FUNERAL DIRECTOR: IMPORTANT

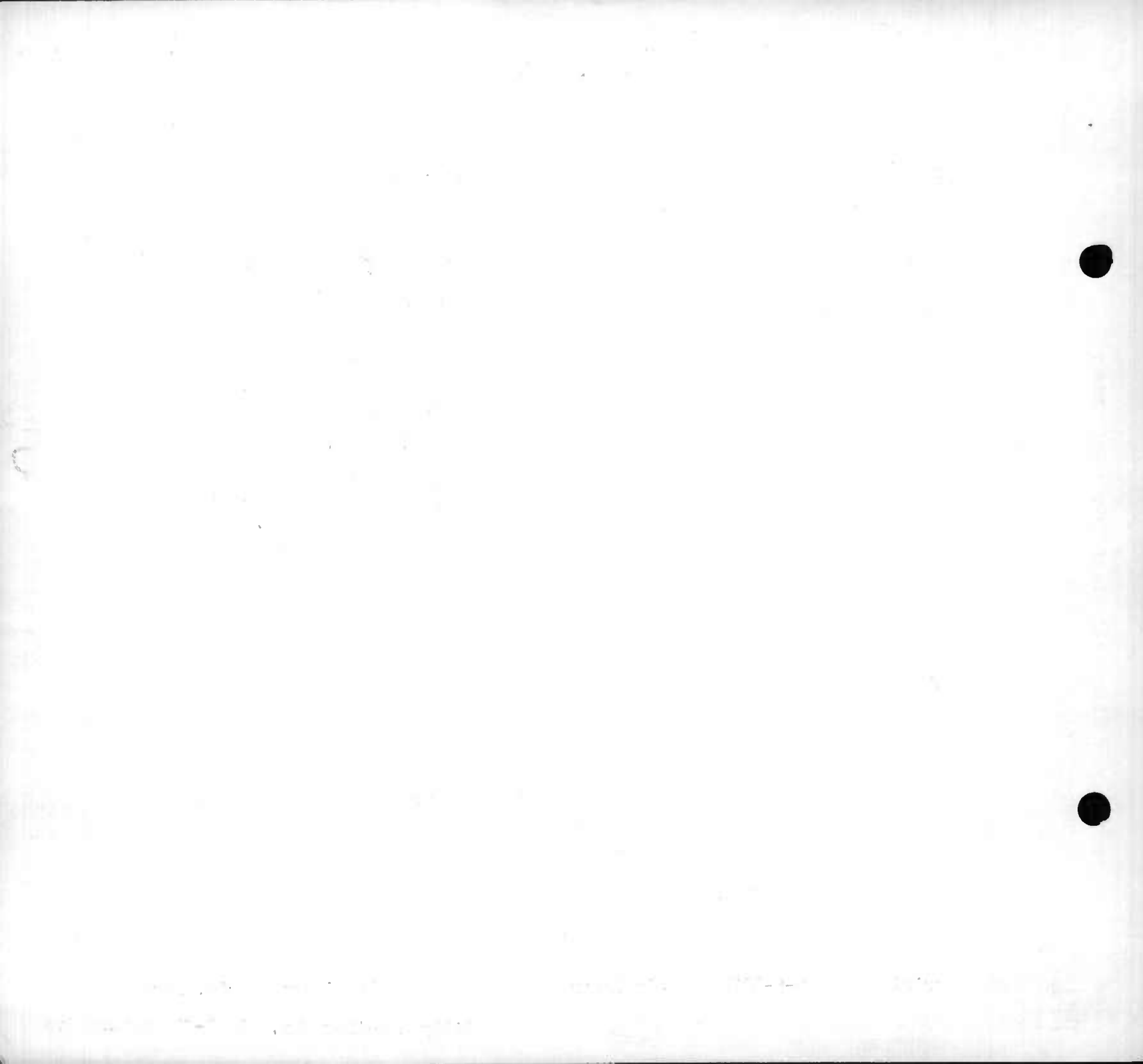
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
D-614		70 5630		70 5630	
1. NAME OF DECEASED (Type or Print) <b>BERTHA A. DORFLER</b>			2. DATE AND HOUR OF DEATH <b>5/31/70</b> <b>11<sup>15</sup> P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>53-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Md. 21224</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>			6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-9-1892</b>			9. AGE (In years last birthday) <b>77</b>		If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			13. FATHER'S NAME <b>Jacob Smith</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>4940 Eastern Ave.</b> ADDRESS <b>BCH Records: Balto., Md. 21224</b>		
18. <b>412.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arrhythmia</b> (B) <b>Digoxin Toxicity</b> (C) <b>ASCDV Recent Myocardial Infarction</b>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>?</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASCDV Recent Myocardial Infarction</b>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			(If in Baltimore City, give exact location)		
22. I certify that (H) (this hospital) attended the deceased from <b>5:30 AM 5/31 1970</b> to <b>11<sup>15</sup> PM 5/31 1970</b> , that (I) (we) last saw the deceased alive on <b>5/31 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James R. Fonk M.D.</b>			23B. DATE SIGNED <b>5/31/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>JAMES R. FONK M.D.</b>			23D. ADDRESS <b>BALTO. CITY HOSP. 4940 - EASTERN AVE.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-4-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
ADDRESS <b>1901-07 Eastern Ave.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5631</u>
BIRTH NO. <u>8-220 70 5631</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>PHILLIP SEIJACK</u>		2. DATE AND HOUR OF DEATH <u>6-1-70 4:40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME &amp; HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>101</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2808 O'DONNELL ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-18</u>	9. AGE (In years last birthday) <u>52</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ALEXANDER SEIJACK</u>		
14. MOTHER'S MAIDEN NAME <u>ROSA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>911-18-6304</u>		17. INFORMANT <u>WIFE</u> ADDRESS <u>2808 O'DONNELL ST.</u>		
18. <u>410.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <u>① Ventricular Tachycardia</u> (A) IMMEDIATE CAUSE <u>Cerebral embolism</u> DUE TO, OR AS A CONSEQUENCE OF: <u>② acute MI</u> (B) <u>SBE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>③ Hypertension</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>16 hrs.</u>
19A. DATE OF OPERATION <u>①</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>May 31 1970</u> to <u>June 1 1970</u> that (I) (we) last saw the deceased alive on <u>June 1 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u>		23B. DATE SIGNED <u>6-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>
23D. ADDRESS <u>100 N. BROADWAY BALT. MD. 21231</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>6-5-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. J. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Lilly &amp; Zedler Inc.</u> ADDRESS <u>1901-07 Eastern Ave</u>





BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Harry Bessin				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 5 31 70 12:15 a.m.			
6. SEX male				7. RACE white			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
9. DATE OF BIRTH MARCH 25, 1914				10. AGE (In years lost birthday) 56			
11. BIRTHPLACE (State or foreign country) HARTFORD, CONN.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR				14B. KIND OF BUSINESS OR INDUSTRY TAVERN			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO. 215-01-6635			
18. INFORMANT MRS. PEARL BESSIN, 6848 WESTRIDGE ROAD				ADDRESS			
19. CAUSE OF DEATH E 812.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Multiple injuries complicated by pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Pratt and Light Sts.				22F. HOW DID INJURY OCCUR? auto-auto collision			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 5 30 70 ?				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. AUTOPSY? (Yes or No) yes			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 5/31/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 6-1-70			
24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT JUN 3 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS			

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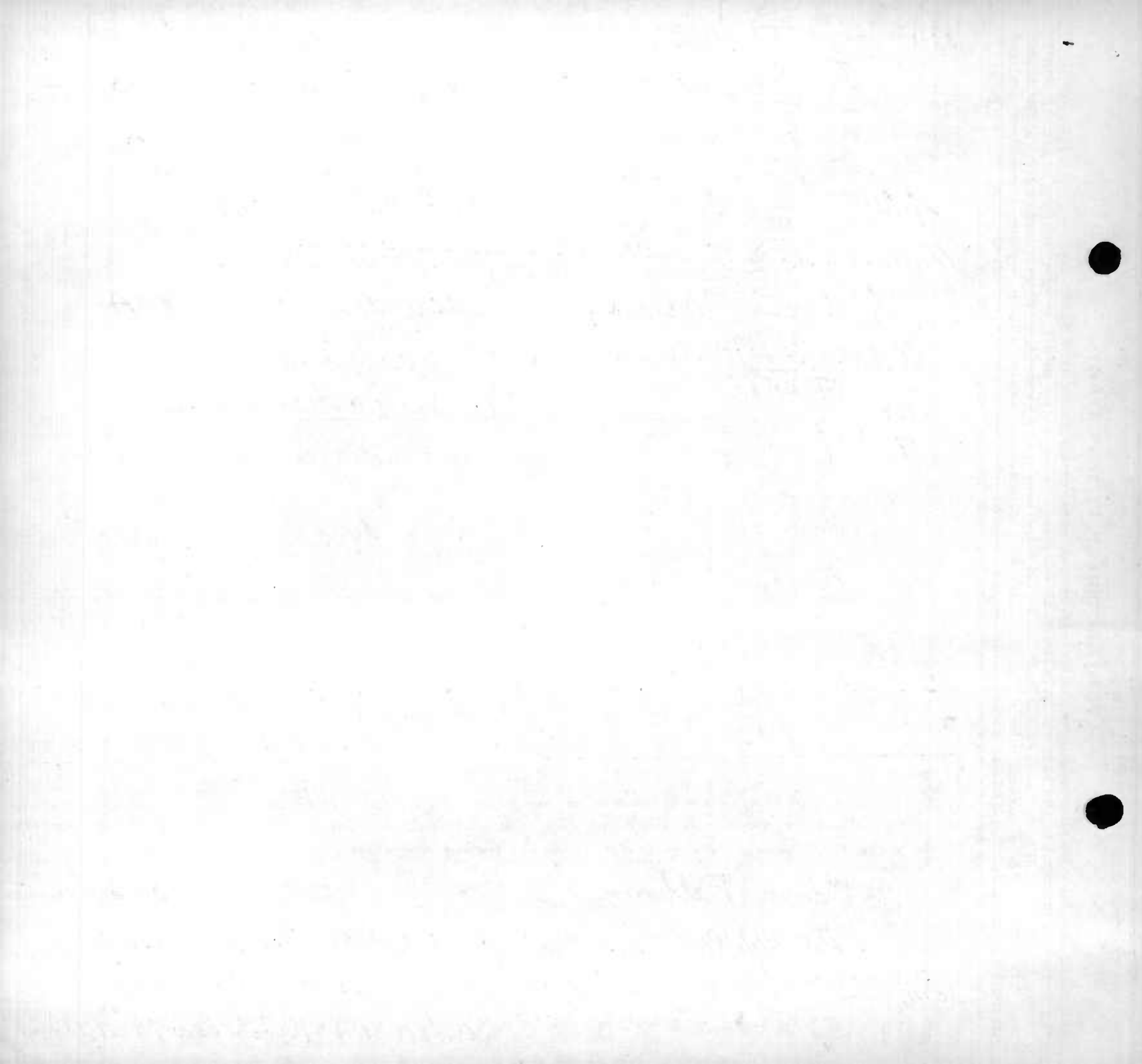
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5633</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.5em;">LEON MARCUS</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.5em;">May 30, 1970 10:15 A.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">Sinai Hospital</span> <span style="font-size: 1.5em;">42</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.5em;">New York</span> B. COUNTY <span style="font-size: 1.5em;">V-29</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.5em;">New York</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.5em;">20 E. 94th Street</span>			
<b>5. SEX</b> <span style="font-size: 1.5em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">Jan 24, 1912</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.5em;">58</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Lawyer</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">attorney</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.5em;">Scranton, Pa</span>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">USA</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.5em;">Adolph Marcus</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.5em;">Anna Ziegler</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.5em;">Kiran Marcus - same</span> <b>ADDRESS</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">acute myocardial infarction</span> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ant. ael. cv. disease</span> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">6 hrs</span> <span style="font-size: 1.5em;">1 hr +</span>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.5em;">none</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.5em;">5/29 19 70</span> <b>to</b> <span style="font-size: 1.5em;">5/30 19 70</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.5em;">5/30 19 70</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Dr. Maurice Feldman</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">5/30/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em;">DR. MAURICE FELDMAN</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">6610 CROSS COUNTRY BLVD.</span>	
<b>24A. BURIAL CREMATION</b> <input checked="" type="checkbox"/> <b>24B. DATE</b> <span style="font-size: 1.5em;">REMOVAL 5/30/70</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.5em;">NEW YORK CITY</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.5em;">NEW YORK CITY</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">JUN 3 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">Robert E. Fisher</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.5em;">Sol Leiman</span>	
<b>ADDRESS</b> <span style="font-size: 1.5em;">Rte - 6000 West. Road</span>					



L-150		70 5634		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 5634						
BIRTH NO.														
1. NAME OF DECEASED (Type or Print) MILTON LAVINE					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital (DOA)					3. DATE PRONOUNCED DEAD Month Day Year Hour 5 31 1970 8:06 A.M.									
6. SEX Male					7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2740					
9. DATE OF BIRTH SEPT. 7, 1915					10. AGE (In years lost birthday) 54		11. BIRTHPLACE (State or foreign country) WINDSOR, O. CANADA		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME SAM LAVINE					14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONNEL MANAGER					15. MOTHER'S MAIDEN NAME REBECCA LITMAN				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II					17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS MRS. ESTHER LAVINE, 6311 PEARCE AVE. #21215							
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease, severe ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
20A. DATE OF OPERATION					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) yes				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street					22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6900 blk. Gist Ave. 18' s. of Fallstaff Ave.				
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 5 31 70 8 A.M.					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					22F. HOW DID INJURY OCCUR? Driver in auto accident.				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					DATE SIGNED 6-1-70									
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL					24B. DATE 6-2-70					24C. NAME of CEMETERY or CREMATORY MACHPELAH CEMETERY				
24D. LOCATION (City, town, or county) (State) FERNDAL, MICHIGAN					25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970					25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				
25C. FUNERAL DIRECTOR Sol Ziviger & Sons					ADDRESS 6010 Reisterstown Rd.									

Kettle from M. E.'s office  
6-5-70 M. H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5635</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">R-251</span>		<span style="font-size: 1.5em;">70 5635</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">LOUIS ROSENBUSH</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">JUNE 1, 1970</span> <span style="float: right;">8 A 4 M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">7008 PARK HEIGHTS AVENUE, APT. H 2</span> <span style="font-size: 1.5em;">00</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">1513</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2008 PARK HEIGHTS AVENUE</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12-2-1880</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">89</span>	<b>If Under 1 Yr. Months: Days:</b> <b>If Under 24 Hrs. Hours: Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">RETIRED SALESMAN</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">MFG. REPRESENTATIVE</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">PHILADELPHIA, PA.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">JACOB ROSENBUSH</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">FANNYE BLUMENTHAL</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MR. LOUIS ROSENBUSH, JR.</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">3502 WOODVALLEY DR.</span>			
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b>  <span style="font-size: 1.2em;">Acute Myocardial Infarction - 2 weeks</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B)</b> <span style="font-size: 1.2em;">Hypertension &amp; Coronal Artery Sclerosis - 2 years</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C)</b> <span style="font-size: 1.2em;">Coronary &amp; Cardiac Infarction - years</span> </div> <div style="width: 10%; text-align: center;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">48 hours</span> </div> </div>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">May 12, 1970</span> <b>to</b> <span style="font-size: 1.2em;">June 1, 1970</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">May 31, 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> <span style="font-size: 1.2em;">June 1-1970</span>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Bernard Cohen</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">June 1 - 1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">BERNARD COHEN M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">The Mayfield Apt - 3501 St. Paul St - Bldg 21218</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6-2-70</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">BALTIMORE, HEBREW</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">REISTERSTOWN, MARYLAND</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 3 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 60709 REISTERSTOWN ROAD</span>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

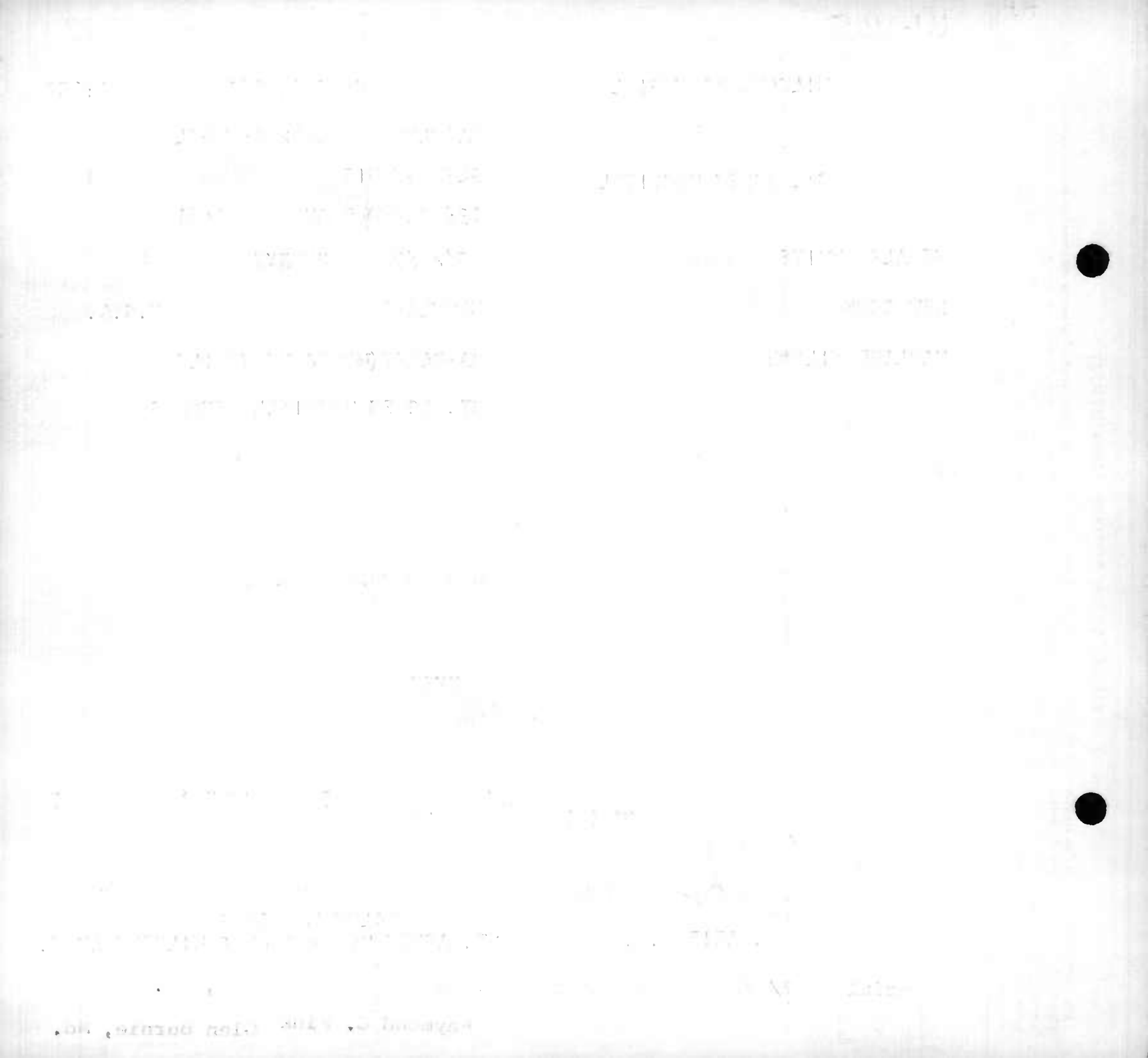
D-500 70 5636		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5636	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DEAN MAUDE</u>		2. DATE AND HOUR OF DEATH <u>June 1, 1970 12:55 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2749</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1623 INGRAM Rd.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-80</u>	9. AGE (in years last birthday) <u>90</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>George Page</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Umberger</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S., A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>J.W.Trew, Country Club Lane, Gettysburg, Pa.</u>	
18. <u>203X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Probably diffuse pulmonary fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Probably secondary CA of lungs</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Possible multiple myeloma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>U</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 22</u> 19 <u>70</u> to <u>June 1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>June 1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Hipolito, M.D.</u>		23B. DATE SIGNED <u>June 1, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>A. Hipolito, M.D.</u>	
23D. ADDRESS <u>Mercy Hospital</u>		23E. NAME OF REGISTRAR <u>M. R. Etchison</u>		23F. FUNERAL DIRECTOR <u>Small &amp; Son, Frederick, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 3, 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick Frederick Md.</u>		24E. DATE RECEIVED BY HEALTH DEPT. <u>JUN 2 1970</u>		24F. NAME OF REGISTRAR <u>M. R. Etchison</u>	
24G. NAME OF REGISTRAR <u>M. R. Etchison</u>		24H. FUNERAL DIRECTOR <u>Small &amp; Son, Frederick, Md.</u>		24I. ADDRESS <u>Small &amp; Son, Frederick, Md.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.5em;">70</span> <span style="font-size: 1.5em;">5637</span>	
<div style="display: flex; justify-content: space-between;"> <span>W-425</span> <span>70-1126870</span> <span>5637</span> </div>				BIRTH NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WILSON, BABY GIRL				JUNE 1, 1970		1:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  ST. AGNES HOSPITAL				A. STATE MARYLAND		B. COUNTY ANNE ARUNDEL	
				C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 136 FAYWOOD AVE		21061	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05/28/70	9. AGE (in years last birthday) XX XX XX	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HARLAND WILSON			
14. MOTHER'S MAIDEN NAME MARGARET (MONTGOMERY) WILSON				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Hemorrhagic Infection of Lungs DUE TO, OR AS A CONSEQUENCE OF:  Anoxia (B) DUE TO, OR AS A CONSEQUENCE OF:  Convulsions & hypoglycemia (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 28 1970 to JUNE 1 1970 that (I) (we) last saw the deceased alive on JUNE 1 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  J. AZIZ M.D.				23B. DATE SIGNED 6-1-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/2/70		Glen Haven Cemetery		Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR Raymond C. Fink		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.	



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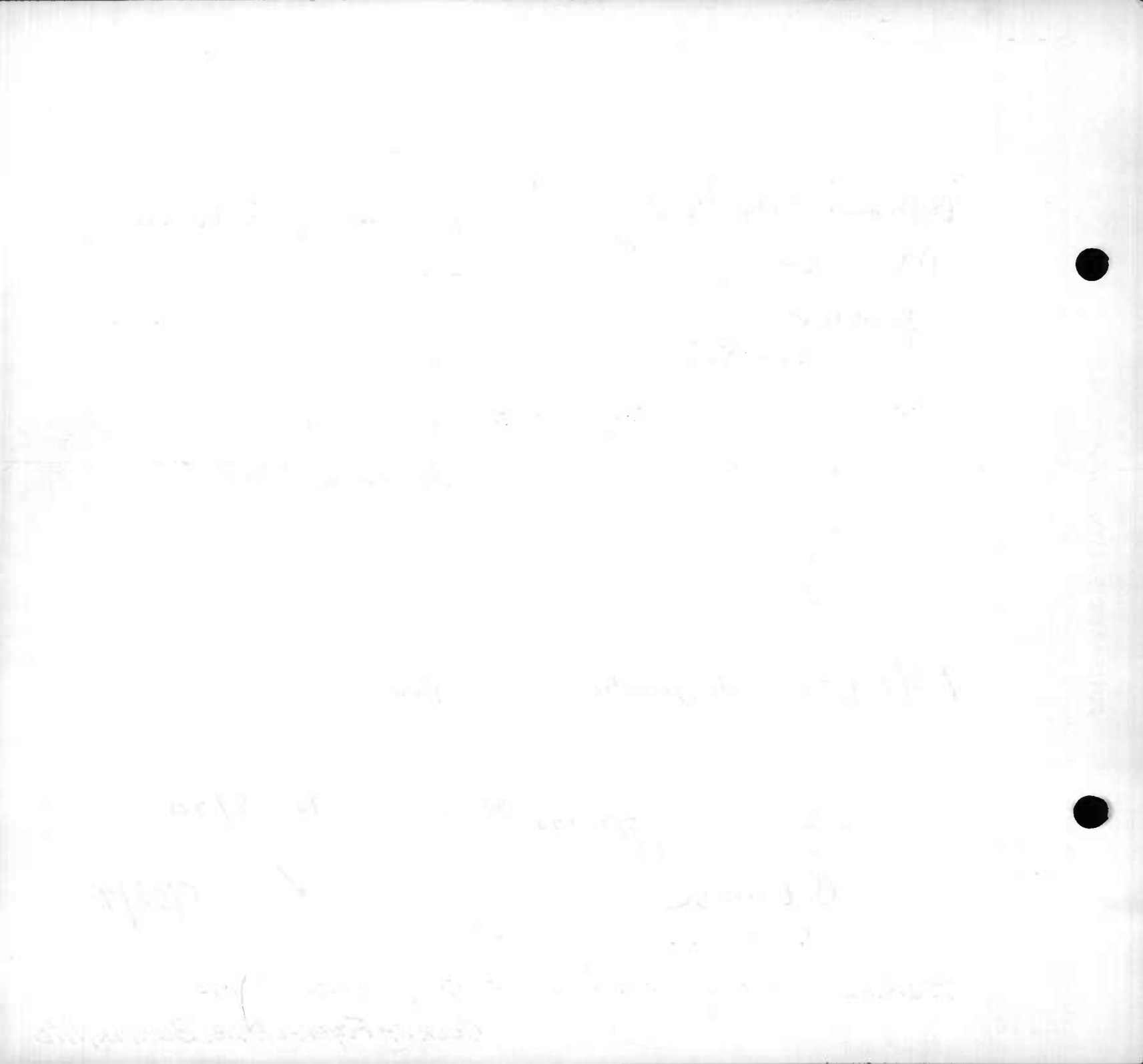
S-460 70 5638		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 5638	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ADILEA C. SCHUYLER		31 May 1970 9:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  90 Gould Convales-arium			A. STATE Md. B. COUNTY 2608		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3426 E. Lombard St. 21224					
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Jan 1903	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick Morgareth		14. MOTHER'S MAIDEN NAME Margaret Ryan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Edw. F. Schuyler, 3426 E. Lombard St. 21224	
18. I, 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Colon Metastasis to abdominal lymphatics Associated Arteriosclerotic C-V disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 15 1970 to May 31, 1970 that (1) (me) last saw the deceased alive on May 31 1970 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (1) (me) (did) (did not) view the body after death.					
23A. SIGNATURE Harold V. Harbold MD				23B. DATE SIGNED June 1, 1970	
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold				23D. ADDRESS 4706 Harford Rd. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3 June 70		24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR Robert E. Jones, MD		25C. FUNERAL DIRECTOR Ulrich Funeral Home, Balto., Md. 21206	
25D. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

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B-563 70 5639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5639	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George Bonhardt</u>		2. DATE AND HOUR OF DEATH <u>5/30/70</u> <u>11:30</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4940 Eastern Avenue Baltimore, Maryland</u> <u>Baltimore City Hosp</u> 21224		E. STREET AND NUMBER <u>1 Liberty Parkway</u> 21222			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-04</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Bonhardt</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Myers</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-5870A</u>		17. INFORMANT <u>BCH, Records Baltimore, Maryland</u> 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>intracranial bleed</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5/29/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>diagnostic</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> 19 <u>70</u> to <u>5/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/30/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Krush</u>		23B. DATE SIGNED <u>5/30/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>C. Krush M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland</u> 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>210670</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Vasey</u>		25C. FUNERAL DIRECTOR <u>U.S. FURNITURE, BALTIMORE, MD.</u>	

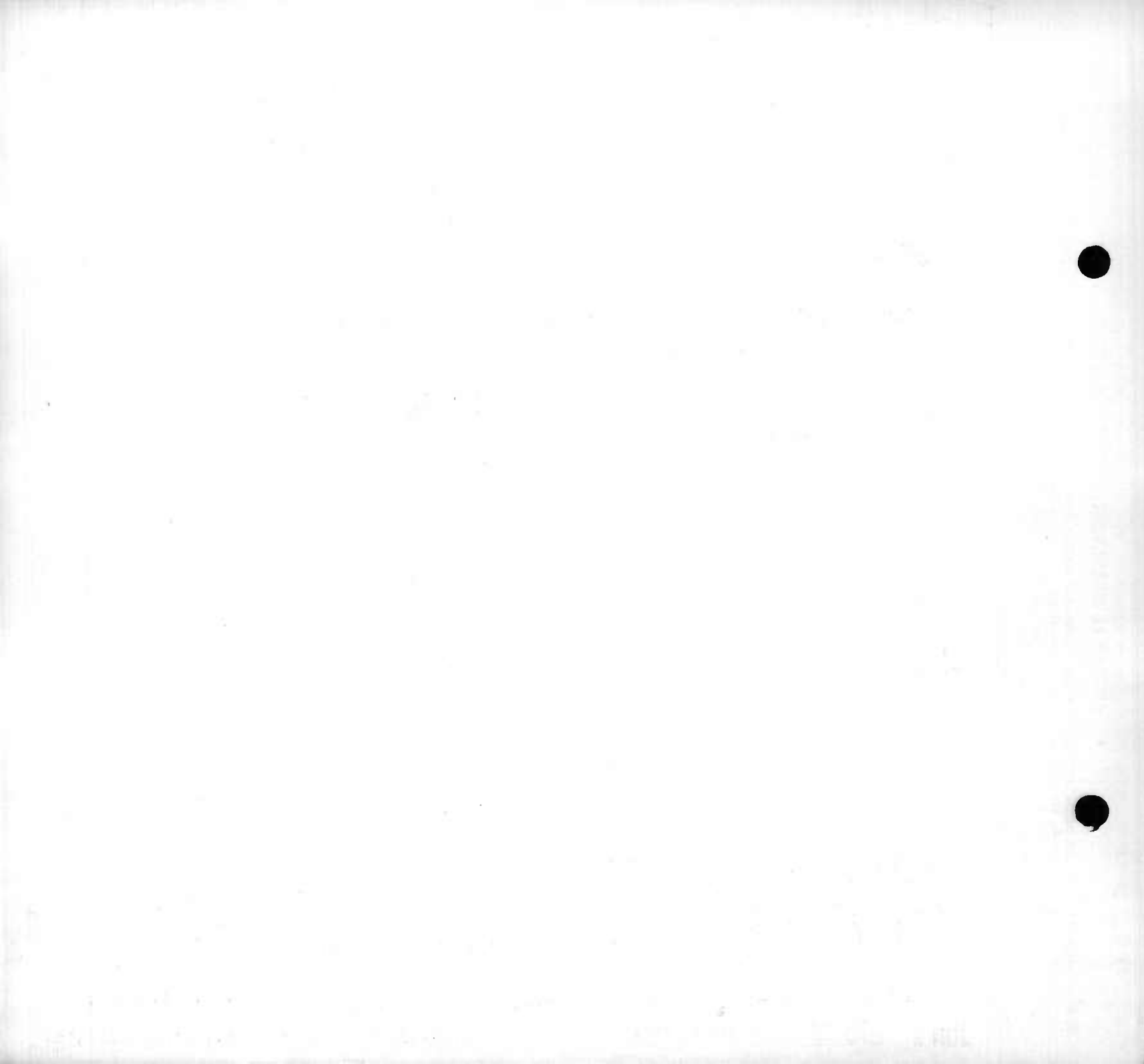




FUNERAL DIRECTOR: IMPORTANT

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B-653 70 5640				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5640	
1. NAME OF DECEASED (Type or Print) <u>Brandt, Harry Charles E</u>				2. DATE AND HOUR OF DEATH <u>5/31/70</u> <u>545</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md Hospital</u>				6. COUNTY <u>Anne Arundel</u>		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
8. SEX <u>M</u>				9. RACE <u>W</u>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. DATE OF BIRTH <u>1-24-95</u>	
12. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				13. AGE (in years last birthday) <u>75</u>		14. If Under 1 Yr. Months Days		15. If Under 24 Hrs. Hours Min.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor</u>				17. KIND OF BUSINESS OR INDUSTRY <u>Metal Fabrication</u>		18. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		19. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
20. FATHER'S NAME <u>Charles T. Brandt</u>				21. MOTHER'S MAIDEN NAME <u>Catherine Kramme</u>					
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW I</u>				23. SOCIAL SECURITY NO. <u>410.94154.1</u>		24. INFORMANT <u>Mrs. Pauline V. Brandt, Gibson Island, Md.</u>		25. ADDRESS	
26. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pulmonary Edema</u>				27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
28. (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Myocardial Infarction</u>				29. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>					
30. (B) DUE TO, OR AS A CONSEQUENCE OF: <u>A. S. N.D.</u>				31. (C) DUE TO, OR AS A CONSEQUENCE OF:					
32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Recent Surgery for Carcinoma Rectum</u>				33. MEDICAL CERTIFICATION					
34. 19A. DATE OF OPERATION <u>5/26/70</u>				35. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adenocarcinoma of Rectum</u>		36. 20A. AUTOPSY? (Yes or No) <u>Yes</u>		37. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
38. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>				39. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		40. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		41. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
42. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				43. 21F. HOW DID INJURY OCCUR?		44. 22. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> 19 <u>70</u> to <u>5/31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/31</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
45. 23A. SIGNATURE <u>M. L. S. Brown</u>				46. 23B. DATE SIGNED <u>5/31</u>		47. 23C. PHYSICIANS NAME (Type) <u>M. L. S. Brown</u>			
48. 23D. ADDRESS <u>University of Md Hosp.</u>				49. 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
50. 24B. DATE <u>6-2-70</u>				51. 24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		52. 24D. LOCATION (City, town, or county) (State) <u>Balto. Co., Md. 21207</u>		53. 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>	
54. 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>				55. 25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Av., Catonsville, Md.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-36270 5641		BALTIMORE CITY HEALTH DEPARTMENT		70 5641	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>SIDERIS, PETER K (Petros)</b>			2. DATE AND HOUR OF DEATH <b>6/1/70 11:40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2864</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>WILKENS &amp; CATON AVE.</b> <b>BALTIMORE, MD. 21228</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>4216 FREDERICK AVE 21229</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-15-00</b>	9. AGE (in years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ASIA MINOR U.S.CITZ</b>	
13. FATHER'S NAME <b>KIRIAKOS SIDERIS DEC 'D</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S. CITZ</b>		
14. MOTHER'S MAIDEN NAME <b>KIRIAKI ORMANDY DEC 'D.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-07-6305</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSP WILKENS &amp; CATON AVE.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9+185X</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute MI</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>P.S.V.D.</b> (C) <b>uroteropathy and Post op 2 weeks</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour.</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>04-20</b> 19 <b>70</b> to <b>06-01</b> 19 <b>80</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>06-01</b> 19 <b>70</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bizhan Ebrahimi</b>			23B. DATE SIGNED <b>96-01-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>BIZHAN EBRAHIMI</b>			23D. ADDRESS <b>M. D. WILKENS &amp; CATON AVE.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/4/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>of Annunciation Greek Orthodox Evangelismos</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert C. Salyer</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 4107 Edmondson Ave., 21229</b>	

8/14/70 - Operation - Ca of Prostate - 2/70

Cause of Death

Myocardial Infarction

Coronary artery disease

ASCVD

Letter in file Bar of Prost-Am. Bldg  
gc

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5642	
X-515 70 5642				70 5642	
BIRTH NO. 70-08790				REG. NO. 70 5642	
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL RAMPMEYER</b>			2. DATE AND HOUR OF DEATH <b>5/31/70 2 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b> <b>35</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b> 6. RACE <b>W</b>			8. DATE OF BIRTH <b>5/30/70</b> 9. AGE (In years last birthday) <b>36</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>		
13. FATHER'S NAME <b>AUGUST A RAMPAYER</b>			14. MOTHER'S MAIDEN NAME <b>ESTHER MARTIN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>—</b> If yes, give war or dates of service <b>—</b>			16. SOCIAL SECURITY NO. <b>911 18 6298</b>		
17. INFORMANT <b>Hospital Chart</b>			ADDRESS <b>2236 Monumental Rd. 21227</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>776.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prematurity</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hyaline membrane disease (Respiratory distress Syndrome)</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2-42 AM 5/30</b> 19 <b>70</b> to <b>2 PM 5/31</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>5/31/70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>M.K. Ghosh M.D.</b>				23B. DATE SIGNED <b>5/31/70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 2 70</b>		24C. NAME of CEMETERY or CREMATORY <b>Crest Lawn</b>	
24D. LOCATION (City, town, or county) <b>Marriottsville Md.</b>		24E. STATE (State) <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke</b>		ADDRESS <b>4101 edmondson Ave. Balto. Md.</b>	

Church Home & Hospital

3086 Broadway St. N.Y.C.

2/2/20

LETTERS FROM

WILLIAM H. KENNEDY

to the Board of Hospital Care

Presidents

Dr. William H. Kennedy

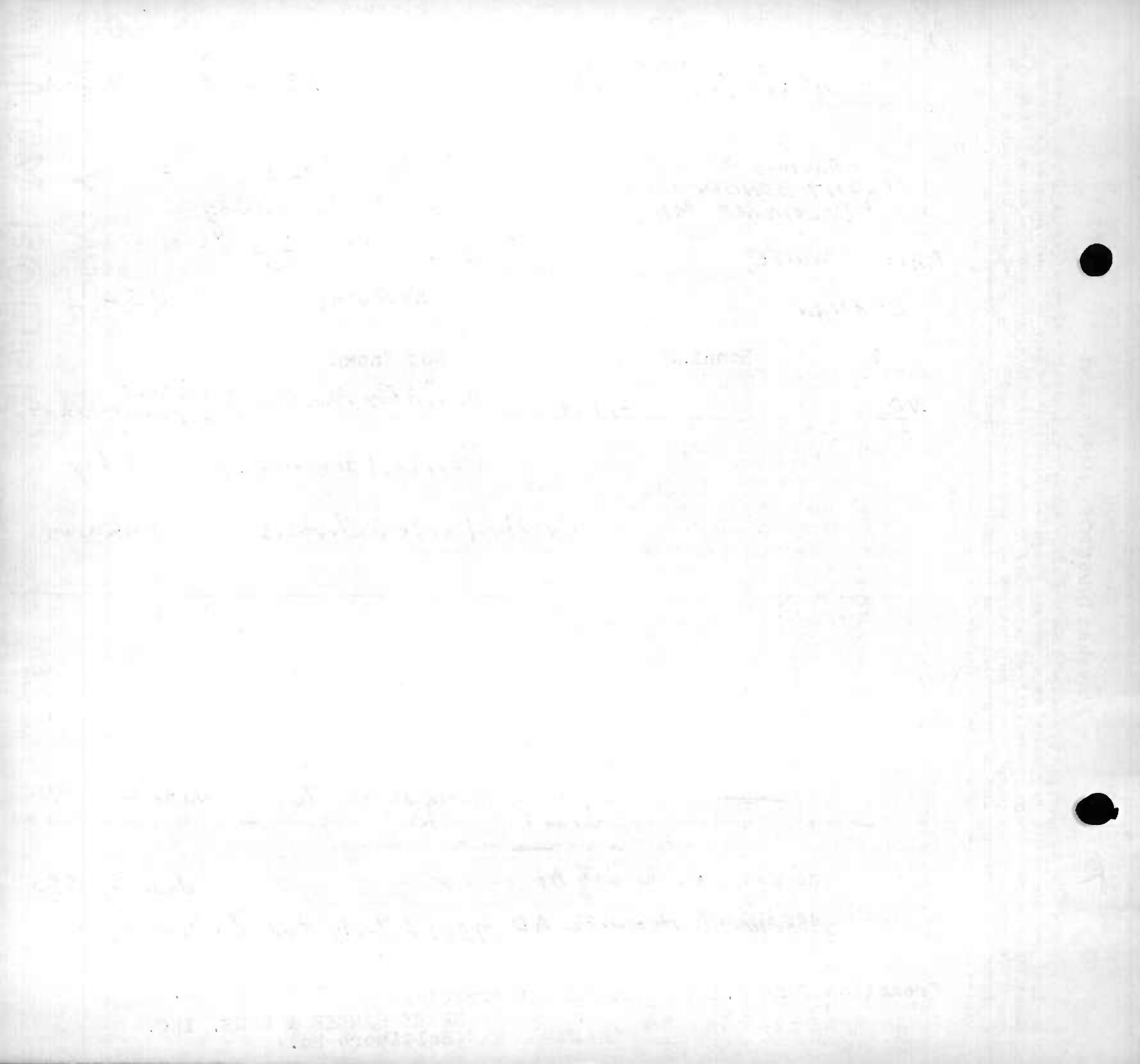
2/2/20

2/2/20

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5643</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">ASKEL RONNING</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">JUNE 2, 1970 11:30 A. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.2em;">CRAWFORD RETREAT</span> <span style="font-size: 1.2em;">2117 DENISEN ST.</span> <span style="font-size: 1.2em;">BALTIMORE, MD.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">202</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>21231</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">227 S. Broadway</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">2-18-85</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SEAMAN</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">NORWAY</span>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">? Ronning</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Not Known</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-14-9391</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Marie A. Fox Adm. Crawford Retreat</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Cerebral thrombosis</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">Cerebral arteriosclerosis</span> DUE TO, OR AS A CONSEQUENCE OF:  (C)		<b>ADDRESS</b> <span style="font-size: 1.2em;">2117 Denisen St.</span>  <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">1 day</span>  <span style="font-size: 1.2em;">unknown</span>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">D</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">NO</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (she) (his) (hospital) attended the deceased from <span style="font-size: 1.2em;">March 16</span> 1970 to <span style="font-size: 1.2em;">June 2</span> 1970, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">June 1</span> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Abraham B. Hurwitz MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">June 2, 1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">ABRAHAM B. HURWITZ MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">7501 Liberty Road, Baltimore, Md.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Cremation June 3, 1970</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">June 3, 1970</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Greenmount Crematorium</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">1970 0000</span>			
<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">HENRY SANDER &amp; SONS. INC.</span>			
<b>25D. ADDRESS</b>		<span style="font-size: 1.2em;">Baltimore Md.</span>			

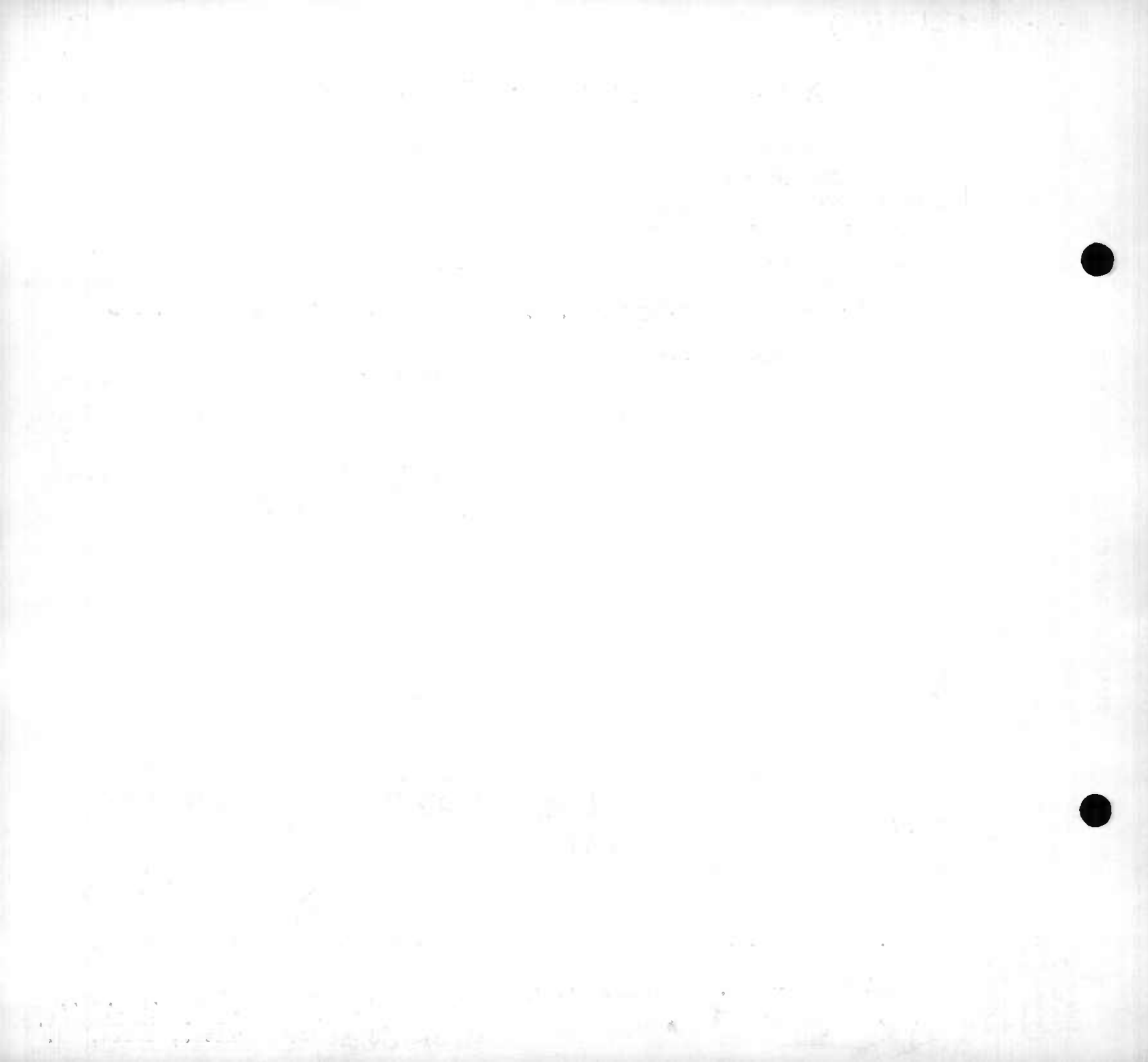




# FUNERAL DIRECTOR: IMPORTANT

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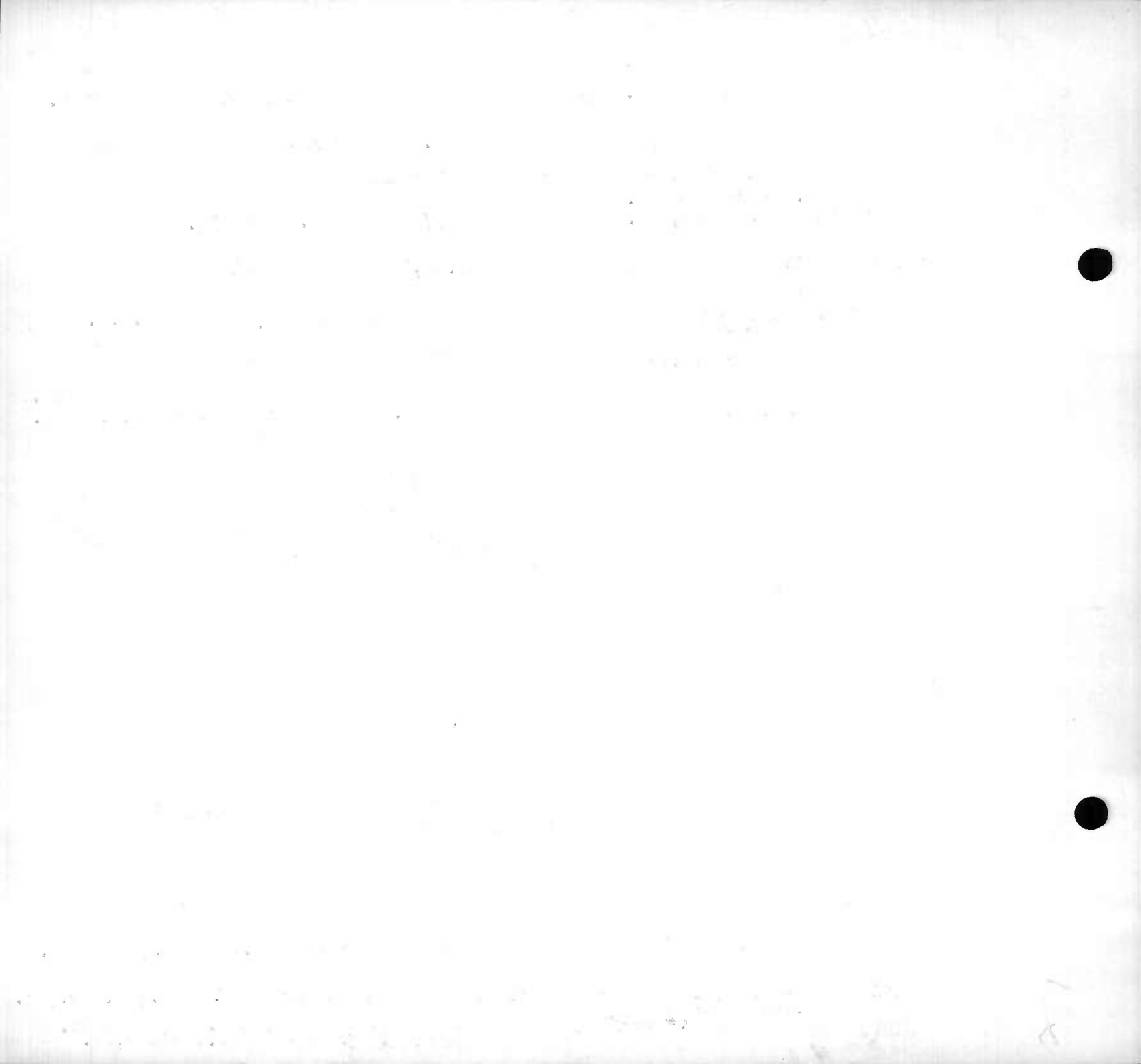
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5644</u>	
BIRTH NO. <u>8-460 70 5644</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Teresa Goeller (TERESA M. GOELLER)</u>		2. DATE AND HOUR OF DEATH <u>May 30, 1970 10:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2609</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3603 Hudson Street 21224</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Varsity Undwr. Co.</u>	9. AGE (in years last birthday) <u>84</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Goeller</u>		14. MOTHER'S MAIDEN NAME <u>Mueller, Regina</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-1657</u>	17. INFORMANT ADDRESS <u>BCH: Records Baltimore, Maryland 21224</u>
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypoxia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Scirrhoux Ca. of Breast</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/27/70</u> 19 to <u>5/30/70</u> 19 that (I) (we) last saw the deceased alive on <u>5/30/70</u> 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>W. Lowell M.D.</u>		23B. DATE SIGNED <u>5/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. Lowell M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-3-70.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd., Ba. Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. ...</u>	25C. FUNERAL DIRECTOR <u>John ...</u>	25D. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 5645	
BIRTH NO. <u>7-460</u>		CERTIFICATE OF DEATH <u>X</u>	
1. NAME OF DECEASED (Type or Print) <b>FRANCES A. ZELIER</b>		2. DATE AND HOUR OF DEATH <b>May 29, 1970 5:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House in the Pines - Belvedere 2525 W. Belvedere Ave. Baltimore, 21215, Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Parkville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2237 Ellen Ave. # 21234.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Work</b>		9. AGE (In years last birthday) <b>81</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Casper Reuter</b>		14. MOTHER'S MAIDEN NAME <b>Dora Miller</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joseph J. Zeller :3113 Kentucky Ave. Balto., Md.</b>		ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute M.V. Atherosclerotic C.V.D.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 10 min 5 min</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 16 1970</b> to <b>May 29 1970</b> that (I) (we) last saw the deceased alive on <b>May 22 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Lester N. Koiman</b>		23B. DATE SIGNED <b>6/1/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>LESTER N. KOIMAN</b>		23D. ADDRESS <b>6821 Reisterstown Rd., Balto., Md.</b>	
24A. REMOVAL OF BODY (Specify) <b>Burial</b>		24B. DATE <b>6-2-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7400 German Hill Rd., Ba. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Zeller</b>	
25C. FUNERAL DIRECTOR <b>Chas. J. Zeller</b>		25D. ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	



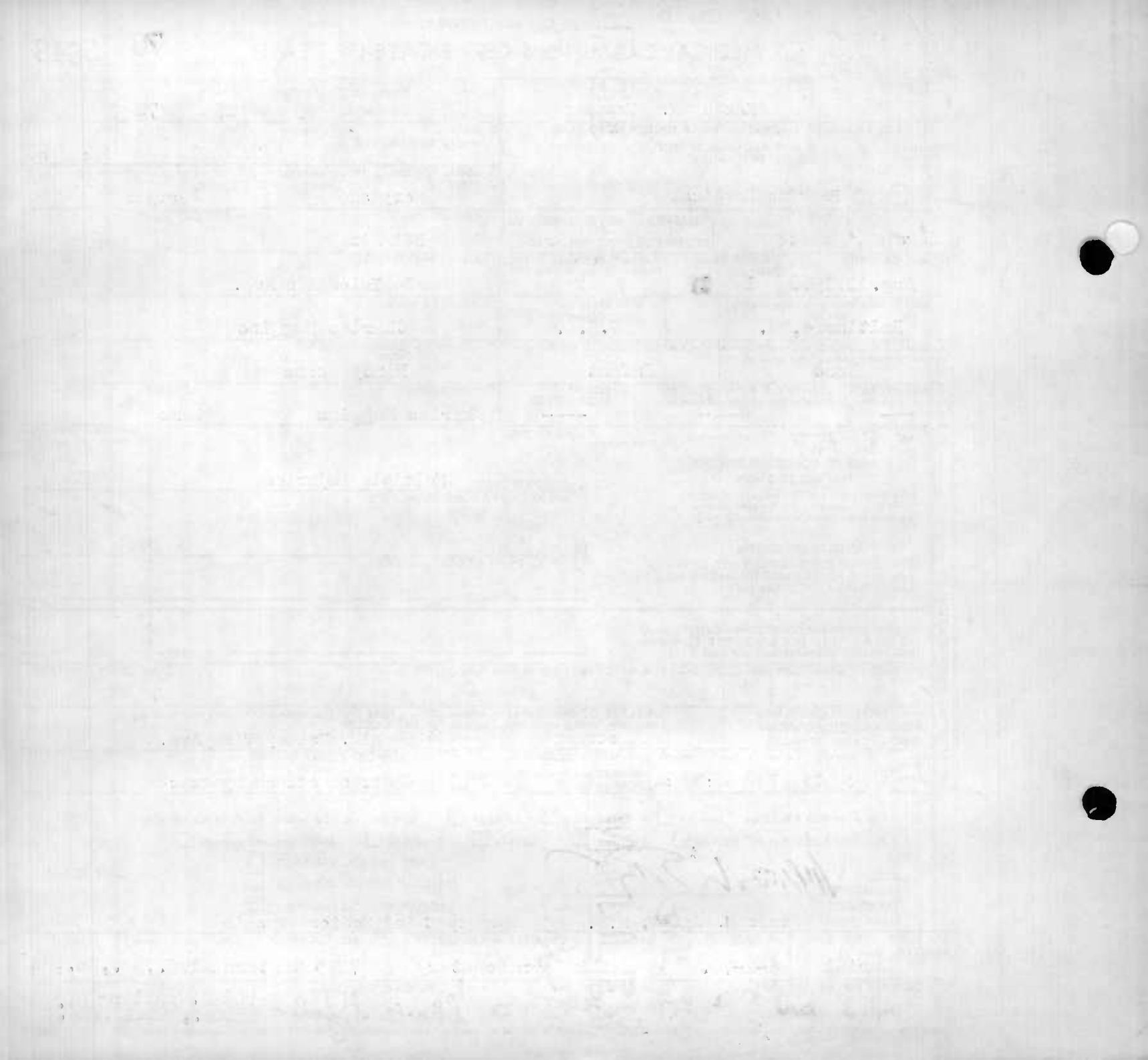
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5646

BIRTH NO. *Balto Co., Md.*

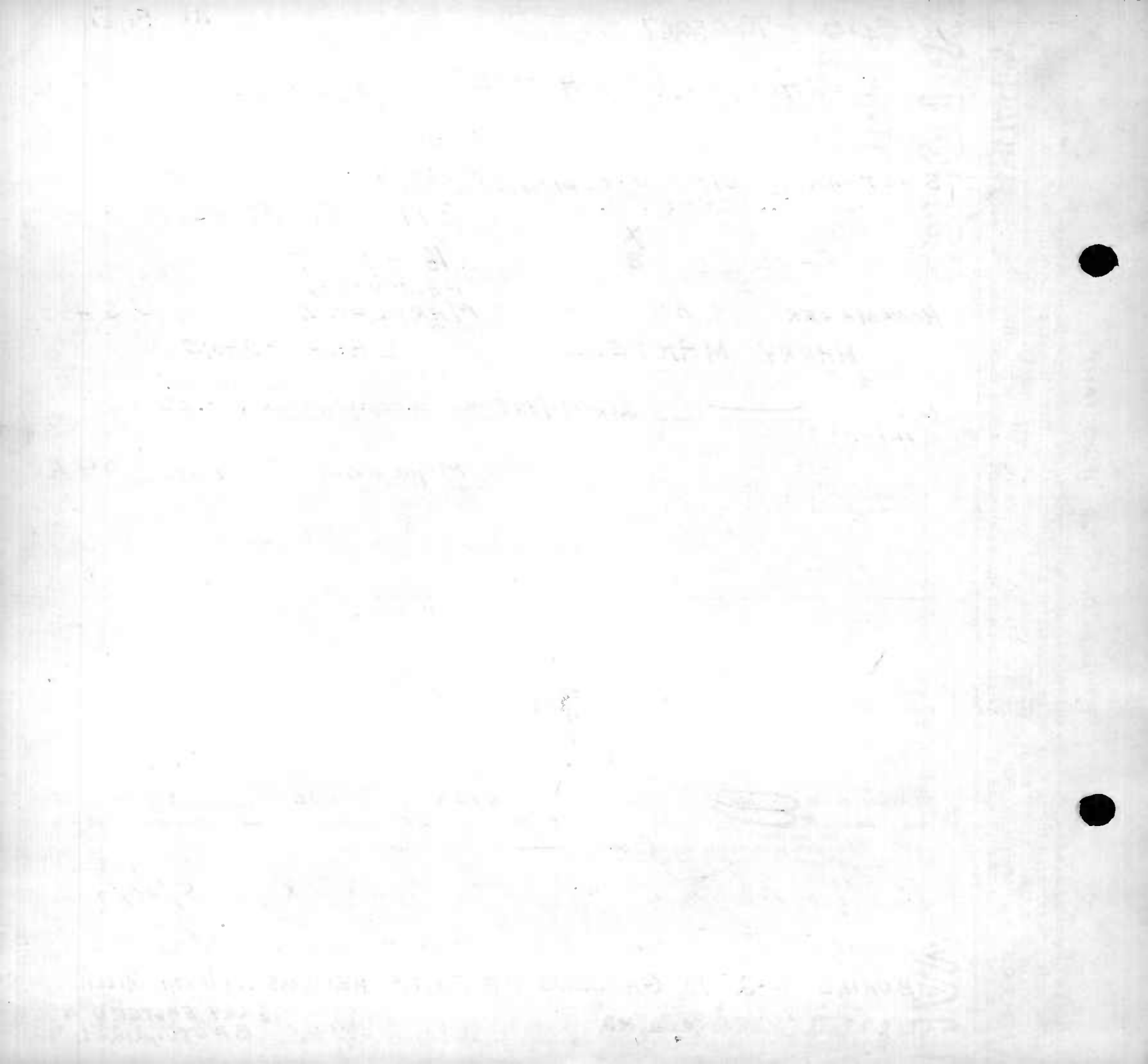
1. NAME OF DECEASED (Type or Print) <b>Karen M. Huggins</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>5 29 70</b>		Hour <b>11:45 a.m.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>5 29 70</b>		Hour <b>11:45 a.m.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>		6. CITY OR TOWN <b>Bel Air</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. SEX <b>female</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>34 Idlewilde Ave.</b>
9. DATE OF BIRTH <b>Aug. 12, 1968</b>		10. AGE (in years last birthday) <b>1</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Huggins</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>
15. MOTHER'S MAIDEN NAME <b>Nancy Johns</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		17. SOCIAL SECURITY NO. <b>Infant</b>
18. INFORMANT <b>Charles Huggins</b>		ADDRESS <b>Same</b>		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E 814.7</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Multiple injuries</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4600 Blk. Valley View Ave.</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>5 29 70 11:30 a.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>pedestrian struck by truck</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/30/70</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-2-70.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba., Co., Md</b>		25A. DATE REC'D BY HEALTH DEPT <b>JUN 3 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Miller, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Geller</b>		
ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELLA MYER (ELLA M. MYER)</b>		2. DATE AND HOUR OF DEATH <b>5/30/70 2:55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITAL</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2607</b>	
5. SEX <b>Female</b>		6. RACE <b>CAUC.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		8. DATE OF BIRTH <b>3/16/97</b>	
13. FATHER'S NAME <b>HARRY MARTELL</b>		14. MOTHER'S MAIDEN NAME <b>LENA ADAMS</b>		9. AGE (In years last birthday) <b>73</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-7428</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
17. INFORMANT <b>4940 Eastern Ave.</b>		ADDRESS <b>BCH Records, Baltimore, Md. 21224</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(A)</del> <b>(this hospital)</b> attended the deceased from <b>5/29</b> 19 <b>70</b> to <b>5/30</b> 19 <b>70</b> , that <del>(I)</del> <b>(we)</b> last saw the deceased alive on <b>5/30</b> 19 <b>70</b> and that <del>in</del> <b>(my)</b> <del>own</del> <b>apinlan</b> death occurred on the date and hour and from the causes stated above. <del>(I)</del> <b>(We)</b> <del>(did)</del> <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Richard M. Thaller MD</b>				23B. DATE SIGNED <b>5/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD M. THALLER MD</b>		23D. ADDRESS <b>4940 Eastern Ave. 21224 BALTIMORE CITY HOSPITAL, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-2-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>	
24D. LOCATION <b>KENWOOD AVE TRUMPS MILL RD. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>			
25B. NAME OF REGISTRAR <b>John E. Taylor, R.R.</b>		25C. FUNERAL DIRECTOR <b>Charles A. Miller</b>			
ADDRESS <b>6224 EASTERN AVE. BALTONA 21224, MD.</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

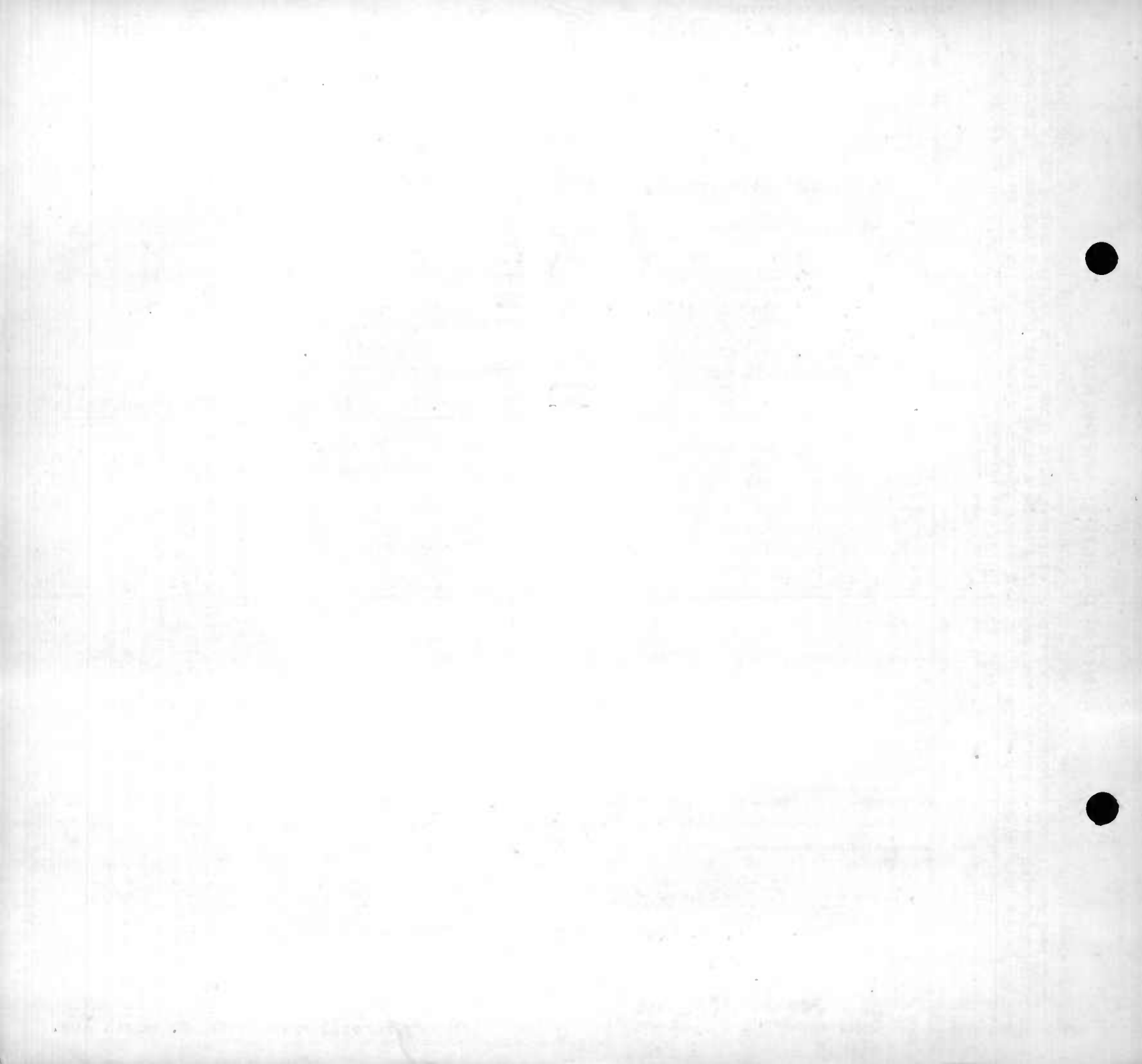
Baltimore City Health Department				REG. NO. <b>70 5648</b>	
BIRTH NO. <b>B-620</b>		70 5648		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>William Brooks</b>			2. DATE AND HOUR OF DEATH <b>May 31, 1970</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1605</b>		
5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>5/1/15</b> 9. AGE (In years last birthday) <b>55</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orderly</b>			11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Lutheran Hospital</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Brooks</b>			14. MOTHER'S MAIDEN NAME <b>Laura ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-16-1712</b>		
17. INFORMANT <b>Mrs. Anna Henson</b>			ADDRESS <b>215 N. Fulton Avenue</b>		
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ISCHEMIC HEART DISEASE &amp; MITRAL REGURGITATION</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 YEARS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY ATHEROSCLEROSIS</b> <b>2 YEARS</b>		
			(B) <b>HYPOTHYROID DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>20 YEARS</b>		
			(C) <b>PERNICIOUS ANEMIA</b> <b>5 YEARS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>11-17</b> <b>1947</b> to <b>5-31</b> <b>1970</b> , that (I) (we) last saw the deceased alive on <b>5-29</b> <b>1970</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <b>Leon Ashman M.D.</b>				23B. DATE SIGNED <b>6-1-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leon Ashman MD</b>				23D. ADDRESS <b>5907 Gwynn Oak Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-5-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co., Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>	
				ADDRESS <b>3035 W. North Avenue</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5649</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">P-626</span> <span style="font-size: 1.5em;">70 5649</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James L. Parker		May 23, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  3400 Gwynns Falls Parkway			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3400 Gwynns Falls Parkway		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/29/13	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) American Smelting & Refining Co.		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jessie L. Parker			14. MOTHER'S MAIDEN NAME Magnolia C. Debnam		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-6838	17. INFORMANT Mrs. Magnolia Parker		
			ADDRESS 3400 Gwynns Falls Pkwy		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bronchogenic Carcinoma of Lung</i></p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i></p> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 1970</i> to <i>May 73</i> 1970, that (I) (we) last saw the deceased alive on <i>May 10</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Emerson R. Julian, M.D.</i>				23B. DATE SIGNED 5/26/70	
23C. PHYSICIAN'S NAME (Type) Emerson R. Julian MD				23D. ADDRESS 2329 Arunah Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial...		24B. DATE 5/27/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970			25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR Nutter Funeral Home
					ADDRESS 3035 W. North Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____	
4-560 70 5650		70 5650		70 5650	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>Addie Henry</b>		2. DATE AND HOUR OF DEATH <b>5/30/70 10-15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>37 Mercy Hospital, Inc.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2710</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4709 Wrenwood Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1893</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Muriell Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary Walley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Mr. Charles L. Henry</b> ADDRESS <b>4709 Wrenwood Avenue</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH 1) ASCVD</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2) chronic congestive heart failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>3) possible bronchopneumonia</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>5/15 1970</b> to <b>5/30 1970</b> and that (I) (we) last saw the deceased alive on <b>5/30 1970</b> and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Makipour</b>		23B. DATE SIGNED _____		23C. PHYSICIAN'S NAME (Type) <b>HOUSHANG - MAKIPOUR</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/4/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE (State) _____		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>	
25B. NAME OF REGISTRAR <b>James E. Rader</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		ADDRESS <b>3035 W. North Avenue</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5651</u>	
1-250 70 5651 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>JACKSON, DEWRY</u>			2. DATE AND HOUR OF DEATH <u>MAY 27 1970</u> <u>2 15 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1204</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u> <u>38</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>MAY-12-1888</u>		9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Apt Houses</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Henry Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Mallory</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>230-26-9089</u>		17. INFORMANT <u>Mrs. Murial Henley</u>
			ADDRESS <u>2325 Guildford Avenue</u>		
18. <u>753.1</u> I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Chronic Renal Failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Polycystic Kidneys</u> life	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Benign Prostatic Hypertrophy</u> <u>years</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 25 1970</u> to <u>MAY 27 1970</u> that (I) (we) last saw the deceased alive on <u>MAY 27 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald S. Pototsky M.D.</u>				23B. DATE SIGNED <u>MAY 27 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD S. POTOTSKY M.D.</u>				23D. ADDRESS <u>UNIVERSITY HOSP BALTO MD 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodland Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley M.D.</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>	
				ADDRESS <u>3035 W. North Avenue</u>	





BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Florence Bowman				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 5 29 70 1:18 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General				3. DATE PRONOUNCED DEAD Month Day Year Hour 5 29 70 1:18 p.m.			
6. SEX female				7. RACE colored			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1402			
9. DATE OF BIRTH 6/1/25				10. AGE (In years last birthday) 44			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Madden				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			
15. MOTHER'S MAIDEN NAME Cora Tarter				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT Mr. James Bowman			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/30/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/3/70			
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970				25B. NAME OF REGISTRAR 2268 E. 22nd St.			
25C. FUNERAL DIRECTOR Nutter Funeral Home				ADDRESS 3035 W. North Avenue			

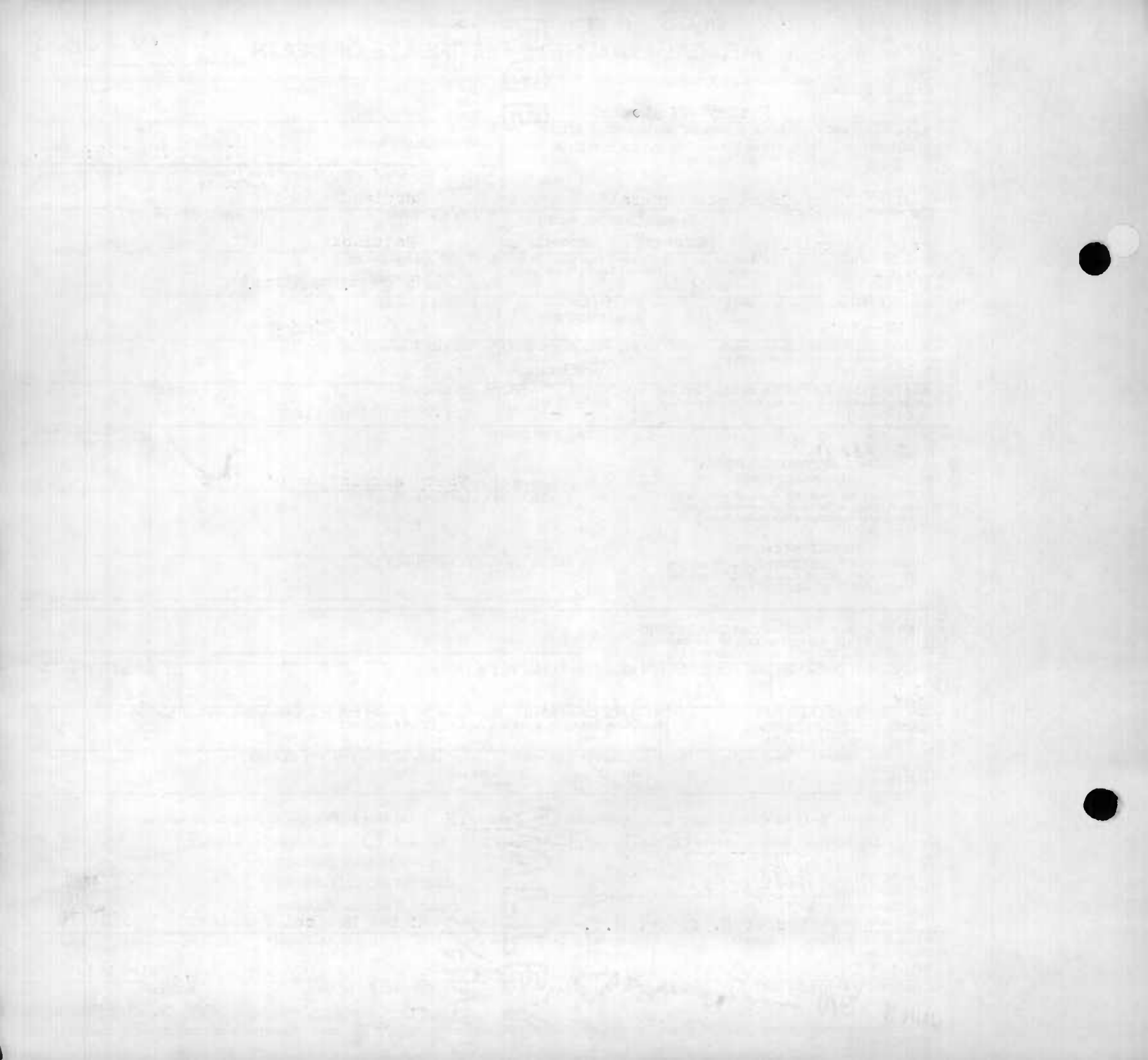


BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

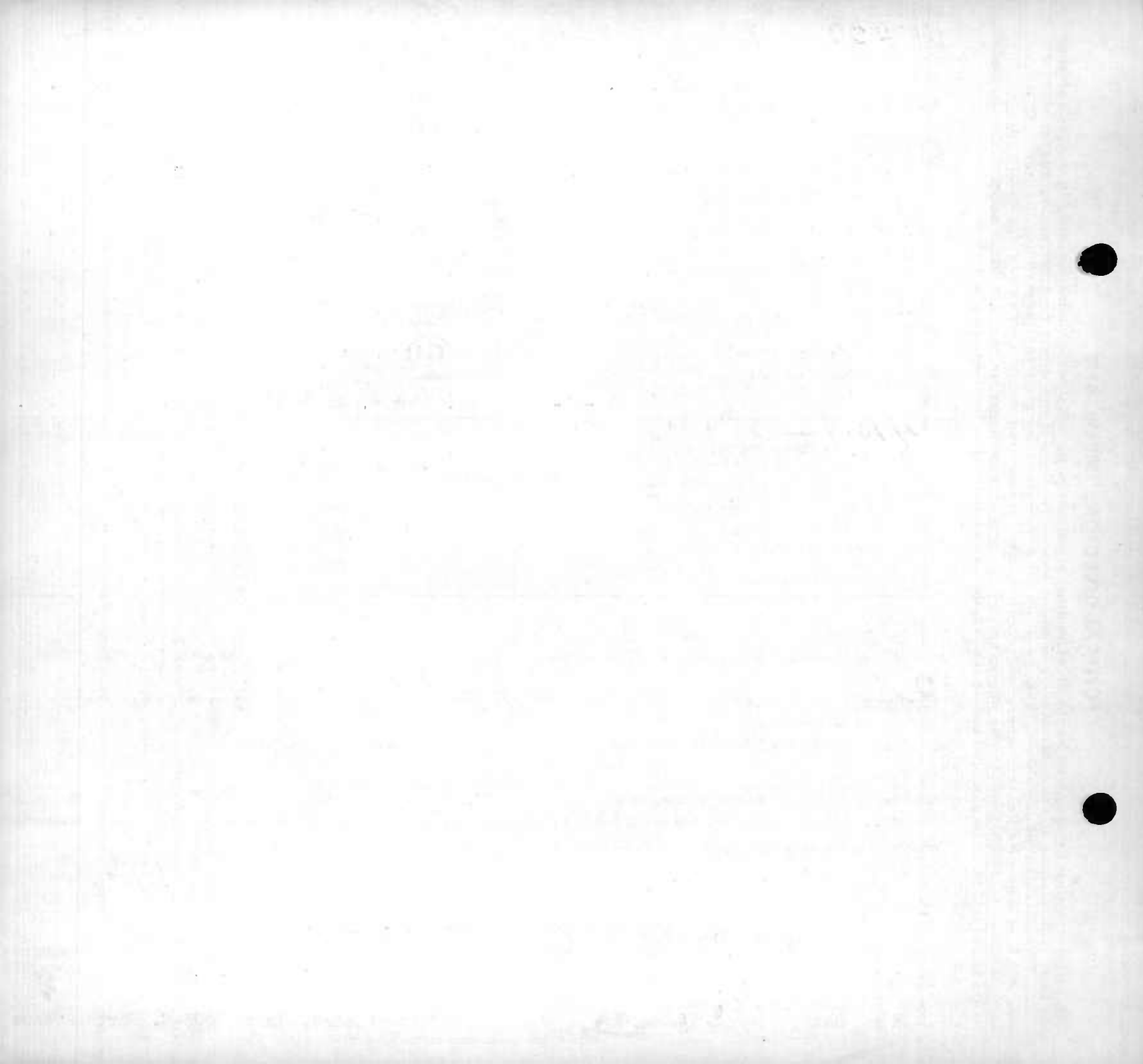
1. NAME OF DECEASED (Type or Print) <p align="center"><b>Hersey Bindom</b></p>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <p align="center">5 31 70 12:15 a.m.</p>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <p align="center"><b>South Baltimore General</b></p>		3. DATE PRONOUNCED DEAD Month Day Year Hour <p align="center">5 31 70 12:15 a.m.</p>	
6. SEX <p align="center"><b>male</b></p>		7. RACE <p align="center"><b>colored</b></p>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1503</b>	
9. DATE OF BIRTH <p align="center"><b>9/6/25</b></p>		10. AGE (in years last birthday) <b>44</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <p align="center"><b>Virginia</b></p>		12. CITIZEN OF WHAT COUNTRY? <p align="center"><b>USA</b></p>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center"><b>Laborer</b></p>		13. FATHER'S NAME <p align="center"><b>James S. Bindom</b></p>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <p align="center"><b>No</b></p>		15. MOTHER'S MAIDEN NAME <p align="center"><b>Mabel Joe</b></p>	
17. SOCIAL SECURITY NO. <p align="center"><b>229-30-3209</b></p>		18. INFORMANT ADDRESS <p align="center"><b>Mrs. Francis Wilson</b></p>	
19. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p align="center"><b>(A) IMMEDIATE CAUSE</b> <b>Fatty alteration of liver</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p align="center"><b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p align="center"><b>(C)</b></p> </div> <div style="width: 15%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <p align="center"><b>yes</b></p>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <b>5/31/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <p align="center"><b>Burial</b></p>		24B. DATE <p align="center"><b>6/5/70</b></p>	
24C. NAME OF CEMETERY or CREMATORY <p align="center"><b>Benlah Land Cemetery</b></p>		24D. LOCATION (City, town, or county) (State) <p align="center"><b>Southampton Co., Virginia</b></p>	
25A. DATE REC'D BY HEALTH DEPT. <p align="center"><b>JUN 3 1970</b></p>		25C. FUNERAL DIRECTOR ADDRESS <p align="center"><b>Nutter Funeral Home 3035 W. North Avenue</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

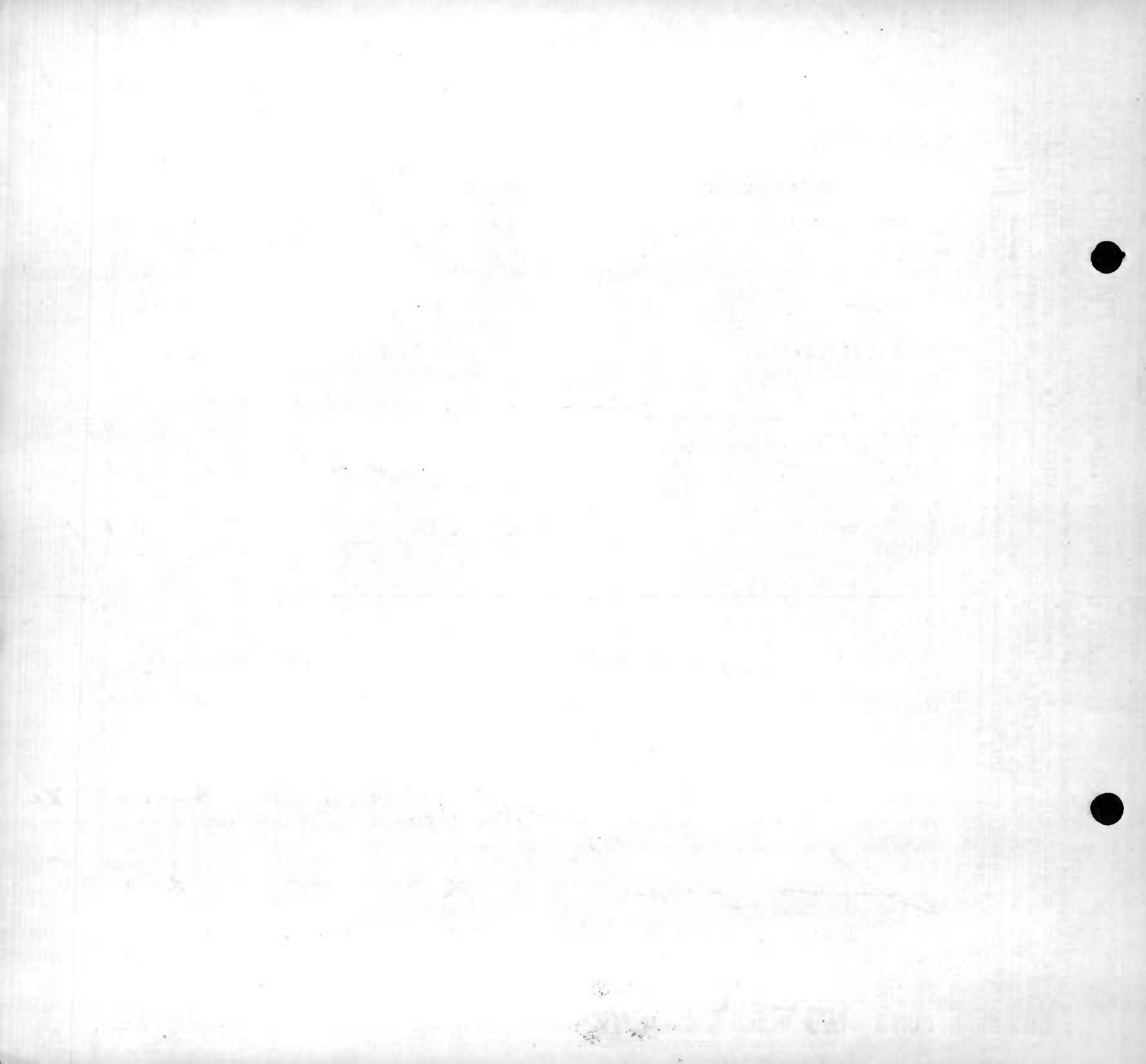
BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. <span style="font-size: 1.5em;">70 5654</span>					70 5654				
BIRTH NO. <span style="font-size: 1.5em;">M-235</span>					70 5654				
1. NAME OF DECEASED (Type or Print) <b>Thaddeus Mc Donald, Sr.</b>					2. DATE AND HOUR OF DEATH <b>5/29/70 10:00 a. M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Pleasant Manor Nursing Home</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1538</b>				
					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <b>3402 Springdale Avenue</b>				
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/85</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Church</b>		11. BIRTHPLACE (State or foreign country) <b>Kingston Jamaica</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Hezekiah Mc Donald</b>					14. MOTHER'S MAIDEN NAME <b>Eliza Braxton</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-12-6304</b>		17. INFORMANT ADDRESS <b>Mrs. Edna M. Mc Donald 3402 Springdale Ave.</b>				
18. <span style="font-size: 1.5em;">4/10/94 258.9</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>					<b>acute</b>				
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD</b>					<b>10 years</b>				
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes</b>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4/13/70</b> 19 to <b>5/29/70</b> 19, that (I) <del>was</del> lost saw the deceased alive on <b>5/14/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.									
23A. SIGNATURE <b>Joseph Shear MD</b>					23B. DATE SIGNED <b>6/1/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Joseph Shear MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, County Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		25D. ADDRESS <b>3035 W. North Avenue</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5655</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Laura Green</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">June 1, 1970</span> <span style="float: right;">10:10 P. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">1701 Braddish Avenue</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">1506</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1701 Braddish Avenue</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">5/15/01</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">69</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">North Carolina</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Jerry Mc Collum</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Emerline ?</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">237-42-7206A</span>		<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Mr. Jerry Mc Collum 1701 Braddish Avenue</span>			
<b>18. CAUSE OF DEATH</b>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 35%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">3 days</span>   <span style="font-size: 1.2em;">2 + years</span> </div> </div>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		(If in Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Aug '68</span> <b>19</b> <b>to</b> <span style="font-size: 1.2em;">June 1</span> <b>19</b> <b>70</b> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">5/30/70</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Lucius W. Leeper</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6-2-70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Lucius W. Leeper MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">2231 Garrison Blvd.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6/5/1970</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Mt Auburn Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 3 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, Jr.</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Nutter Funeral Home 3035 W. North Avenue</span>			

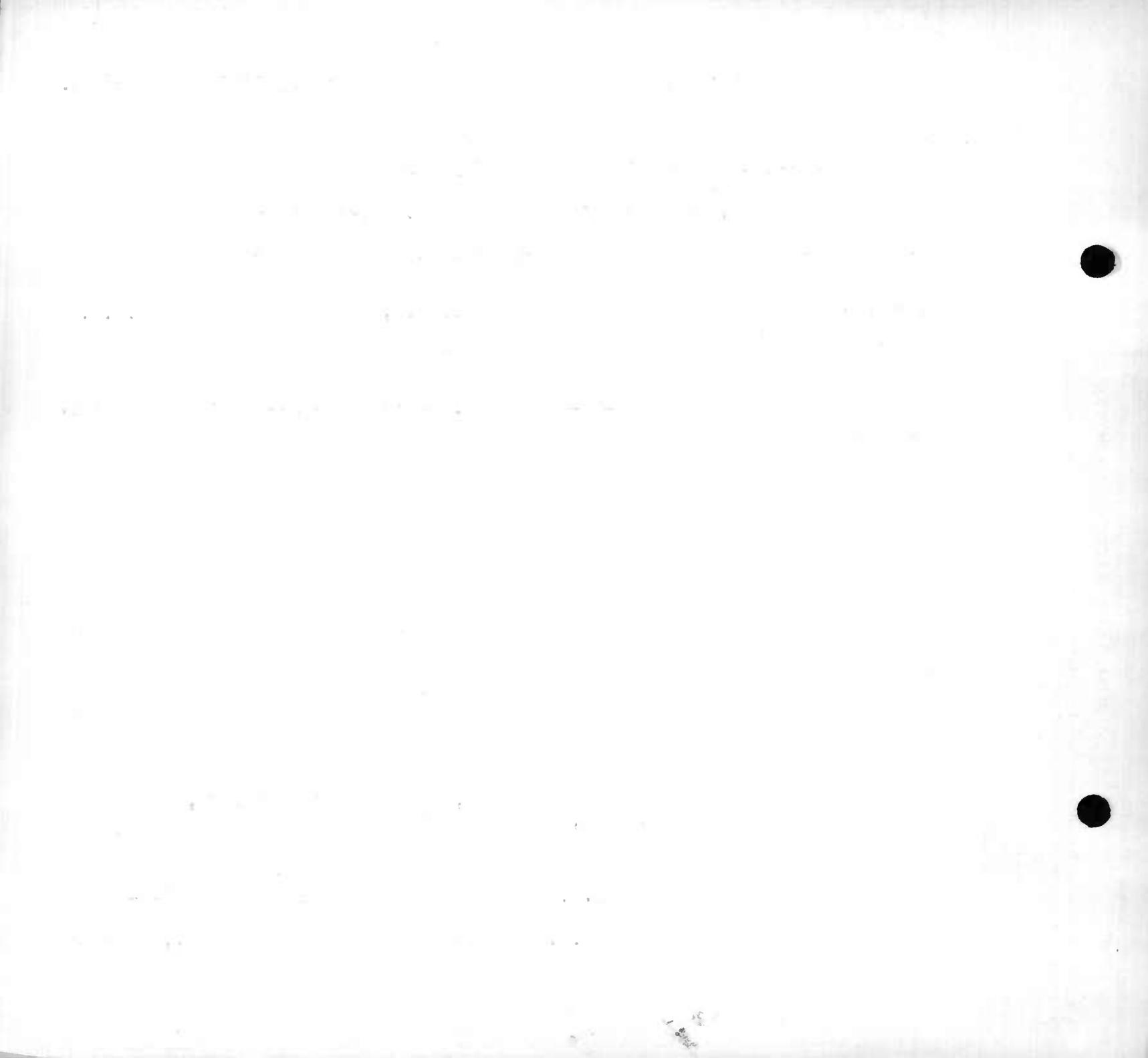




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

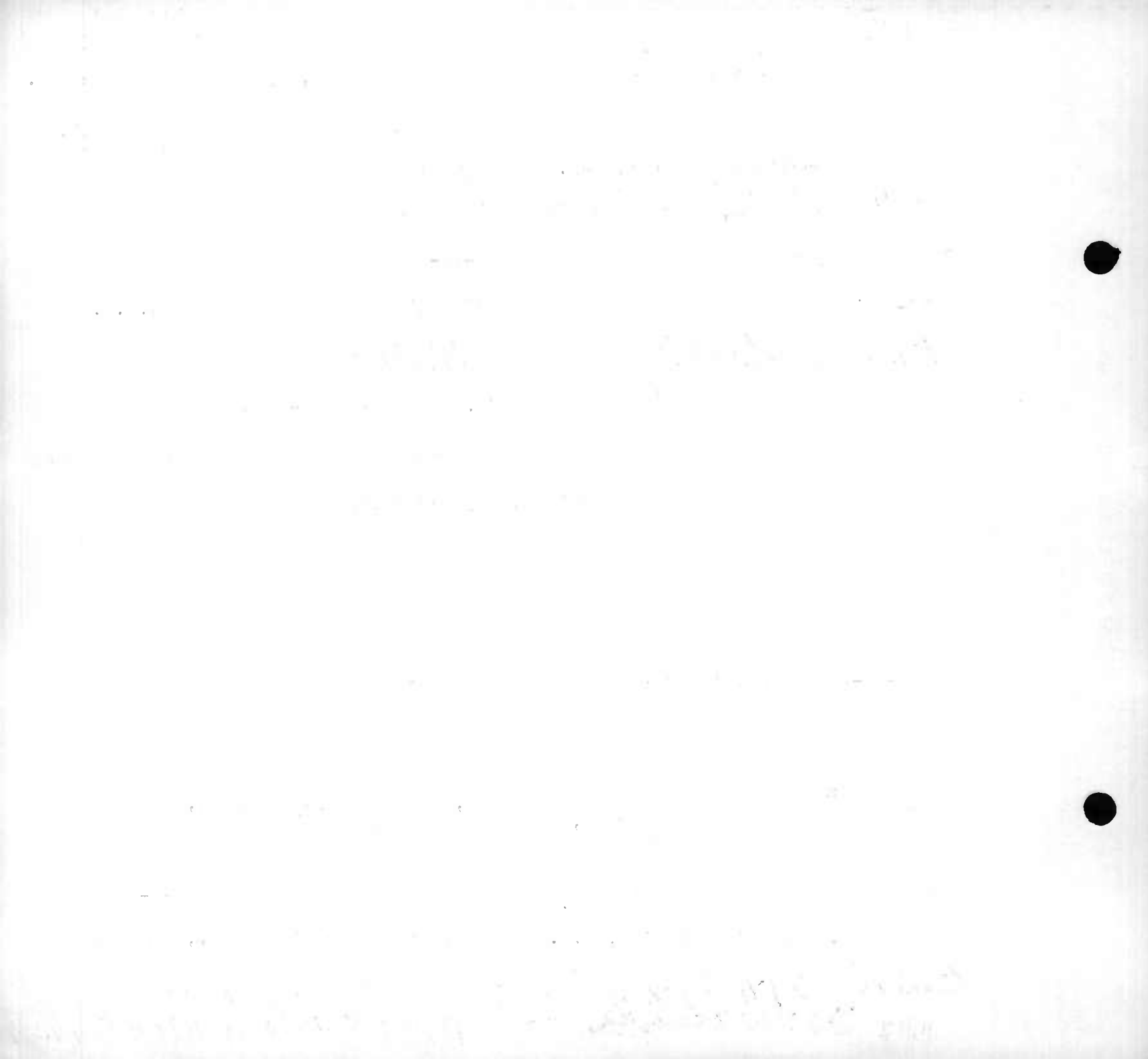
BALTIMORE CITY HEALTH DEPARTMENT				70 5656		CERTIFICATE OF DEATH		70 5656	
BIRTH NO. <u>3-516</u>				1. NAME OF DECEASED (Type or Print) <u>Robert Gambrill</u>		2. DATE AND HOUR OF DEATH <u>May 31, 1970</u>		1:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1601</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>1033 N. Carey Street</u>					
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-09</u>		9. AGE (in years last birthday) <u>60</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School System</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Gambrill</u>				14. MOTHER'S MAIDEN NAME <u>Jones Estella</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-09-9263</u>		17. INFORMANT <u>Mrs. Beatrice Lewis- Sister</u>		ADDRESS <u>Same</u>	
18. <u>5710 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Alcoholism</u>				CAUSE OF DEATH <u>Cirrhosis of Liver &amp; Jaundice + Ascites</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Alcoholism</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one month</u> <u>many years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pneumonia + Multiple D. S. Ulcerations</u>								<u>one week</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>May 15,</u> 19 <u>70</u> to <u>May 31,</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>May 31,</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Roland T. Smoot</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6-1-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT</u> M.D.				23D. ADDRESS <u>1514 Division Street Balto., Maryland</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>E. J. ...</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>		ADDRESS <u>3035 W. North Avenue</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5657	
BIRTH NO. 70 5657		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gertrude Barner		2. DATE AND HOUR OF DEATH May 30, 1970		10:00 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 221 Joppa Road			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-20	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME R. L. Lashley		14. MOTHER'S MAIDEN NAME Mollie?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Felton Barner- Husband	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MASSIVE PULMONARY CONGESTION 24 hours		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (Pulmonary Infarction) (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3 5-21-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibroid Uterus		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 18, 1970 to May 30, 1970 that (I) (we) last saw the deceased alive on May 30, 1970 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Franklin Phillips, M.D.		23B. DATE SIGNED 6-2-70		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREATION, REMOVAL (Specify)		24B. DATE 6/4/70		24C. NAME OF CEMETERY OR CREMATORY Belts National Cem	
24D. LOCATION 5501 Belts Rd. Md.		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR Mollie S. Chickory- 1129 N. Lombard	
25A. DATE REC'D BY HEALTH 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



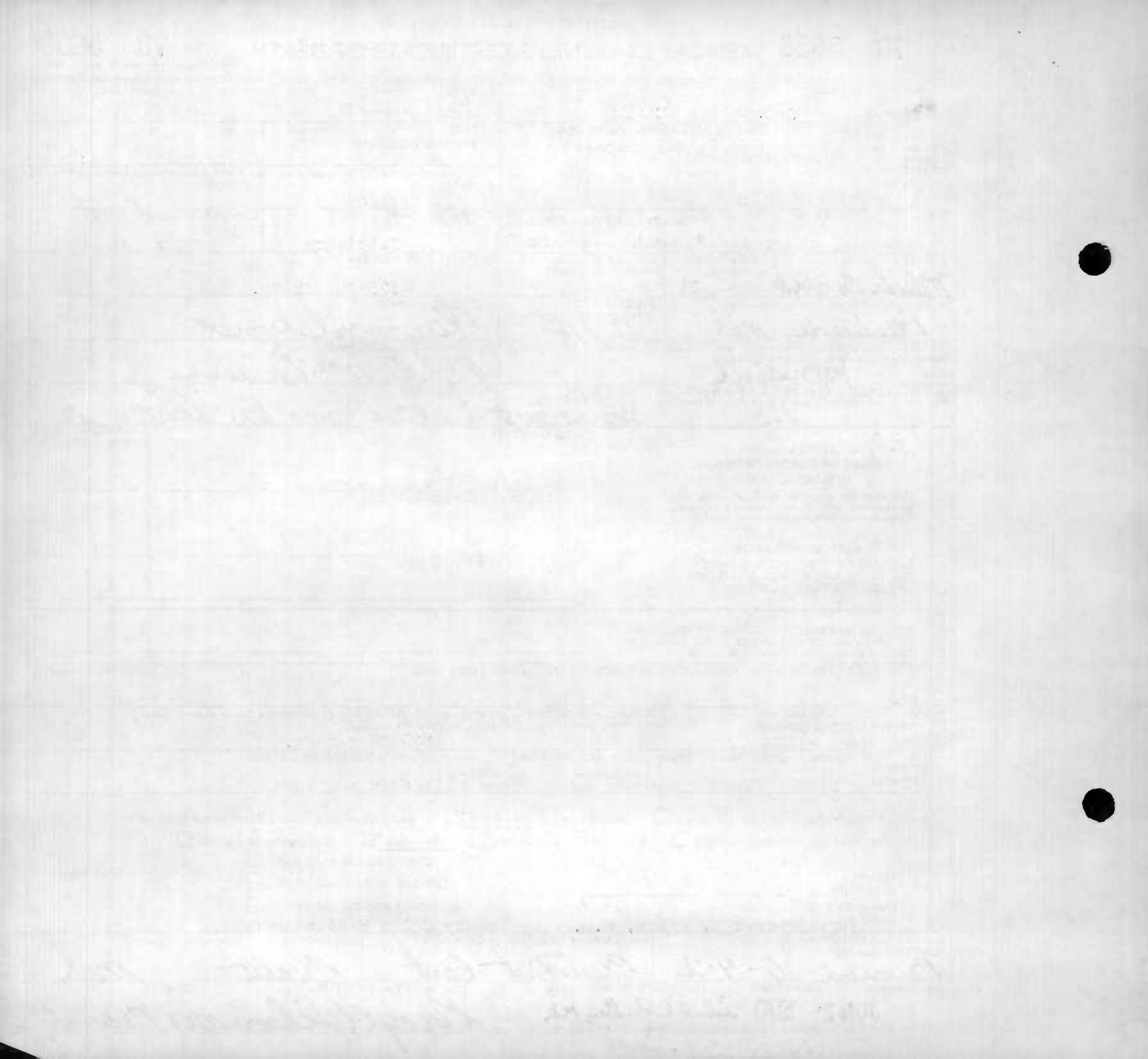
C-462

70 5658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5658

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jacqueline Clark		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 30 70 11:21 p.m.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704	
6. SEX female	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH March 30 1948	10. AGE (In years last birthday) 21	E. STREET AND NUMBER 825 Shuter St.	
11. BIRTHPLACE (State or foreign country) Baltimore Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Raymond Jones	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Pearl McQueen	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 216-57-2165	18. INFORMANT ADDRESS Delora Jones 825 Shuter St.
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9651		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 825 Shuter St. 704		22F. HOW DID INJURY OCCUR? beaten and shot	
22D. TIME OF INJURY (APPROX.) 5 30 70 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 5/31/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-4-70	
24C. NAME OF CEMETERY or CREMATORY Baltimore Natl Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Elroy Wilson		ADDRESS 1000 Beatty St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5659		REG. NO. 70 5659	
BIRTH NO. <span style="font-size: 1.5em;">R-543</span>		70 5659		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HOWARD E. REYNOLDS</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6-1-70</span> <span style="font-size: 1.5em;">9:45 AM</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">BON SECOURS EMERG. RM.</span>				A. STATE <span style="font-size: 1.5em;">MD</span>		B. COUNTY	
				C. CITY OR TOWN <span style="font-size: 1.5em;">BALTO</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.5em;">2122 W BALTO ST</span>			
5. SEX <span style="font-size: 1.5em;">M</span>	6. RACE <span style="font-size: 1.5em;">N</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">3-16-10</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">60</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">LABORER</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">BALTO MD</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">MATTHEW REYNOLDS</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">DORA JACKSON</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">X</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.5em;">DORA REYNOLDS</span>		ADDRESS <span style="font-size: 1.5em;">2122 W. BALTO ST</span>	
18. <span style="font-size: 1.5em;">162.1 I</span> <b>CAUSE OF DEATH</b>  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">Pt pneumonia</span> 20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)  21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  21F. HOW DID INJURY OCCUR?  22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Sept</span> 19 <span style="font-size: 1.5em;">69</span> to <span style="font-size: 1.5em;">May</span> 31 19 <span style="font-size: 1.5em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">May 2</span> 19 <span style="font-size: 1.5em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  23A. SIGNATURE <span style="font-size: 1.5em;">Arthur Harris MD</span> 23B. DATE SIGNED <span style="font-size: 1.5em;">6-1-70</span> 23C. PHYSICIAN'S NAME (Type)  23D. ADDRESS <span style="font-size: 1.5em;">John Hopkins Hospital</span> 23E. DEGREE  23F. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span> 24B. DATE <span style="font-size: 1.5em;">6/5/70</span> 24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">Mt Auburn</span> 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">BALTO MD</span> 25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 3 1970</span> 25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Fisher, Reg.</span> 25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">M. J. Harris</span> 25D. ADDRESS <span style="font-size: 1.5em;">638 N. Gilem or St</span>							





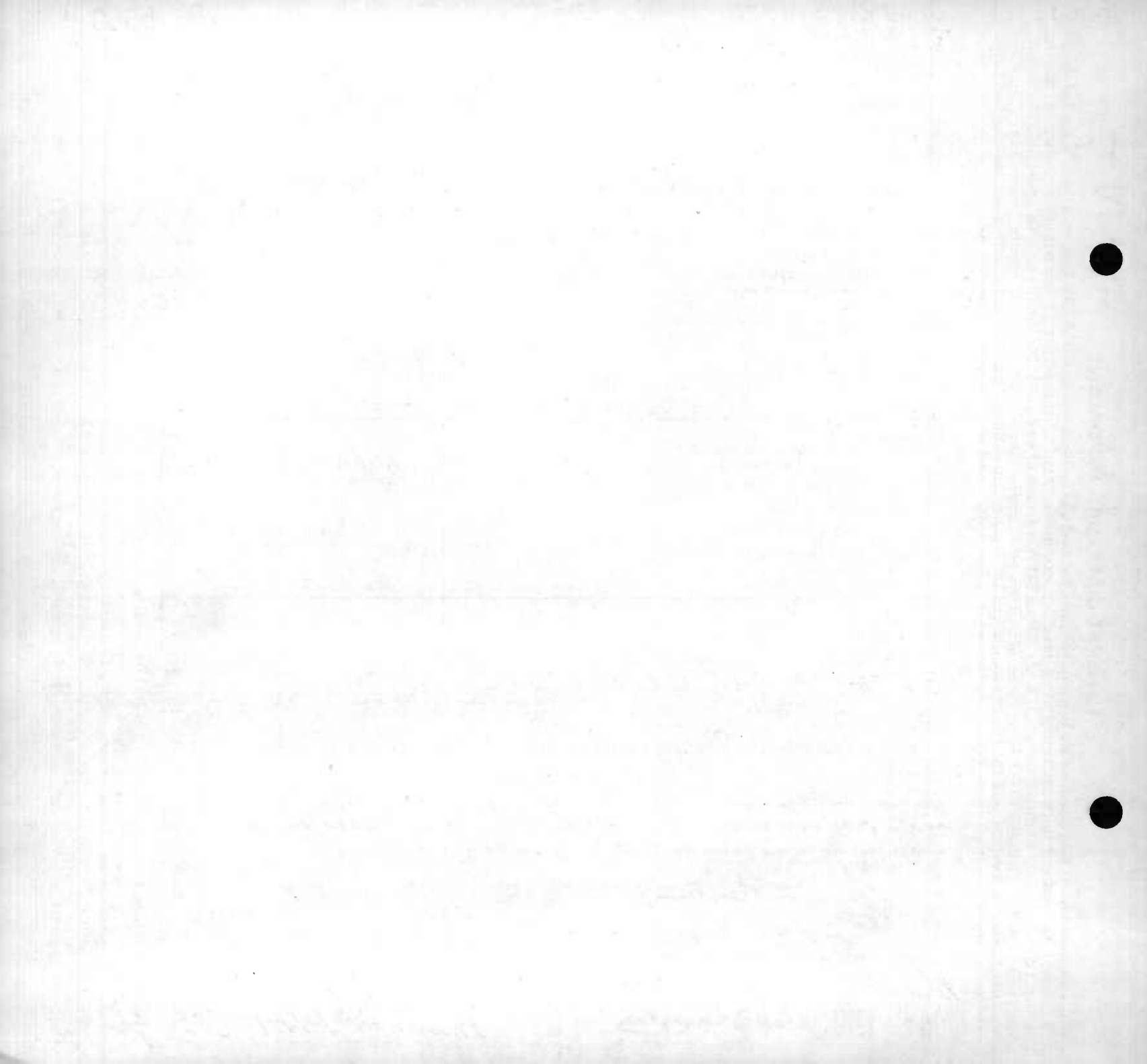
## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 70 5660

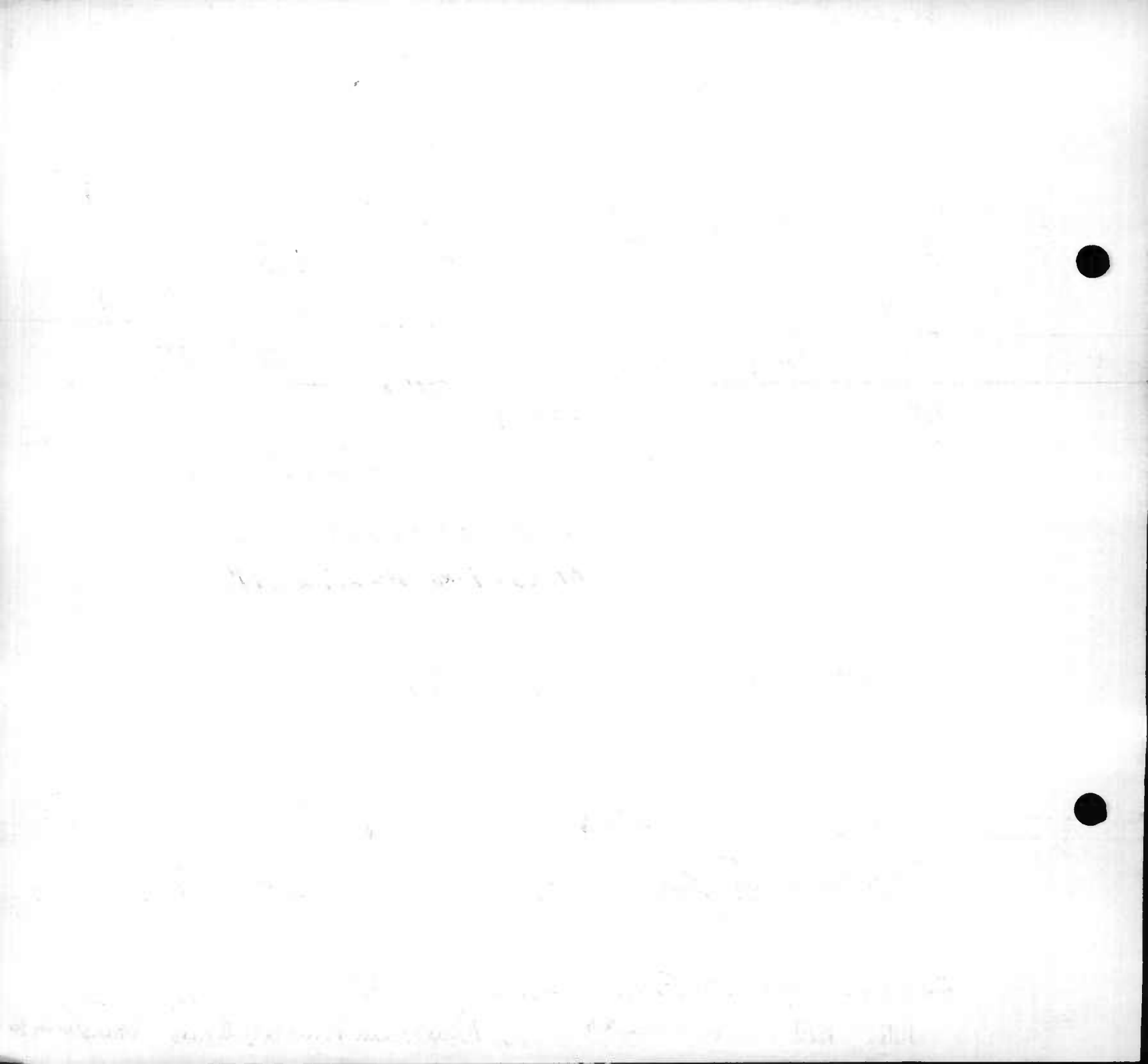
BIRTH NO. 70 5660		1. NAME OF DECEASED (Type or Print) HAWTHORNE, CLAUDIA		2. DATE AND HOUR OF DEATH 6/1/70 12:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO		5. CITY OR TOWN BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITAL Baltimore, Md. 21224		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1738 SMALLWOOD ST. 71215	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/14	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WARREN HAWTHORNE		14. MOTHER'S MAIDEN NAME Mary Kele	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 223-09-7920		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224	
18. 725.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLUS.			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC TUBERCULOSIS.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/5/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemodialysis		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/12/70 19 to 6-1-70 19 that (I) lost saw the deceased alive on 5/31/70 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/1/70	
23C. PHYSICIAN'S NAME (Type) Bruce Northrup MD		23D. ADDRESS 4940 Eastern Avenue BALTO. CITY HOSPITAL BALTO, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/70		24C. NAME OF CEMETERY OR CREMATORY MT AUBURN	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (State) MD			
25A. DATE RECD BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature] 638 N GILMAN ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

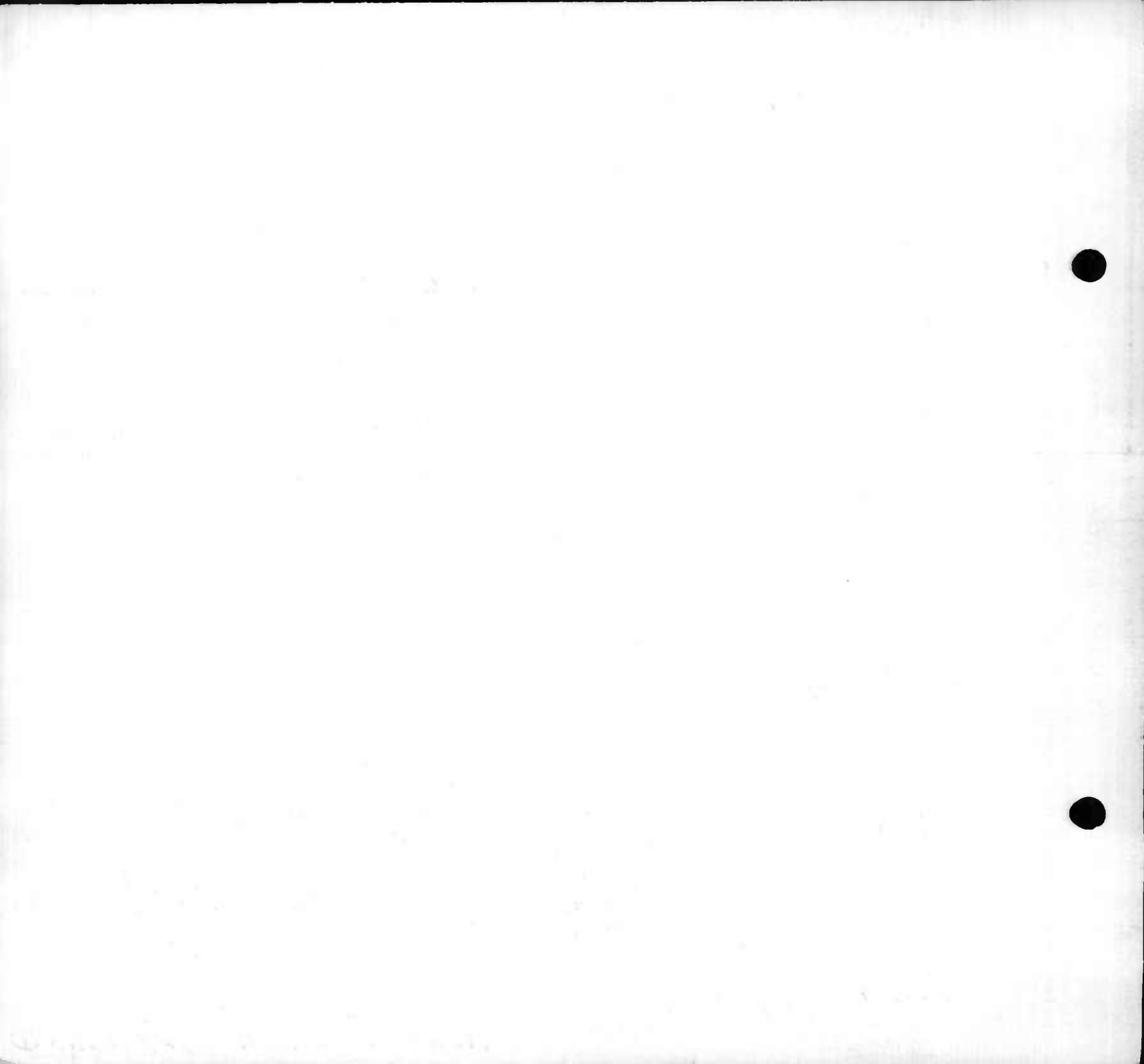
B-530 70 5661		BALTIMORE CITY HEALTH DEPARTMENT		70 5661	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JAMES W. BENNETT		MAY 28, 1970		11:42 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
UNIVERSITY HOSPITAL		A. STATE DELAWARE		B. COUNTY V-07	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN LAUREL		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER RD #3			
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/07	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JONATHAN WM. BENNETT		14. MOTHER'S MAIDEN NAME N. HOMI Nichols		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 222-24-0137		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONITIS ACUTE RENAL FAILURE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GANGRENOUS GALL BLADDER (B) DUE TO, OR AS A CONSEQUENCE OF: NECROTIZING MYO-FASCITIS (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 5/23/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NECROTIZING FASCITIS		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 23 1970 to MAY 28 1970 that (I) (we) last saw the deceased alive on MAY 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
22A. SIGNATURE Martin E. Lips M.D.		22B. DATE SIGNED May 29 1970		23. PHYSICIAN'S NAME (Type) DEGREE	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/1/1970		24C. NAME OF CEMETERY OR CREMATORY FIREMEN'S	
24D. LOCATION SHARPTOWN, MD		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Deborah Funeral Home	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400 5662		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH X	
1. NAME OF DECEASED (Type or Print) <u>CAHALL, SYLVIA C.</u>		2. DATE AND HOUR OF DEATH <u>29 May 1970 1:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University of Md Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>21st &amp; B 70-29</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md Hospital</u>		C. CITY OR TOWN <u>EASTON</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/27/42</u> 9. AGE (in years last birthday) <u>28</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>JANE WILSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ROBERT W. CAHALL, EASTON, MD</u>		ADDRESS	
18. <u>747.81</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Intracerebral Hemorrhage</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral Malformation</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>26 MAY 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Malformation</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/21/70</u> 19 <u>70</u> to <u>5/29</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5/29</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Edward D. Layne</u>		23B. DATE SIGNED <u>29 MAY 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDWARD D. LAYNE</u>		23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/2/1970</u>	
24C. NAME OF CEMETERY or CREMATORY <u>SPRING HILL</u>		24D. LOCATION (City, town, or county) (State) <u>EASTON, MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR <u>NEW NAME FUNERAL HOME, EASTON, MD</u>		ADDRESS	



JMK

## FUNERAL DIRECTOR: IMPORTANT

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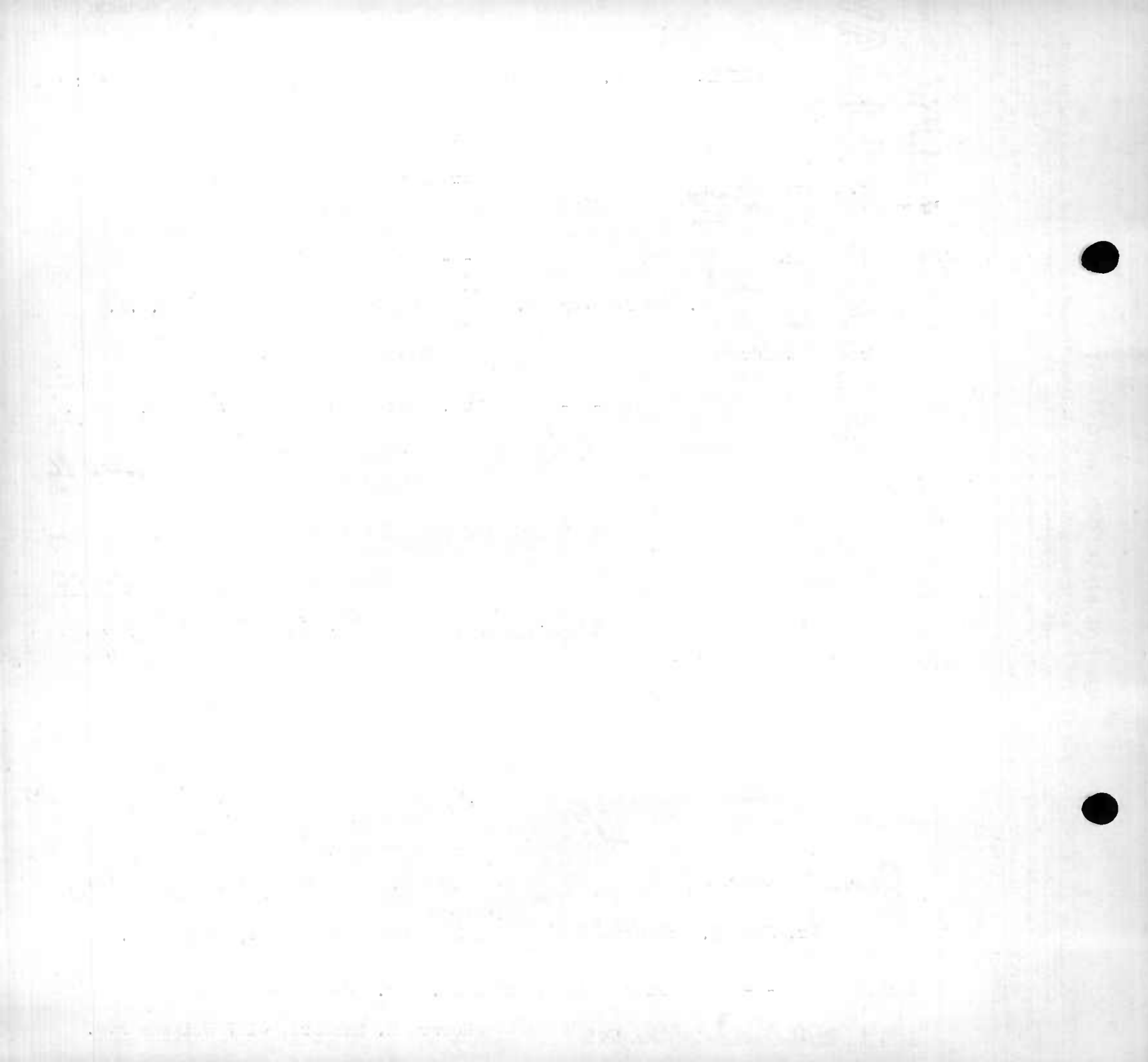
BIRTH NO. <u>7-512</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5663</u>	
1. NAME OF DECEASED (Type or Print) <b>THOMPSON, PAUL RAYMOND</b>			2. DATE AND HOUR OF DEATH <b>JUNE 1, 1970 12:45 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21229 2551</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SHIPBUILDING</b>		8. DATE OF BIRTH <b>05/13/00 70</b>
13. FATHER'S NAME <b>CHARLES THOMPSON</b>			14. MOTHER'S MAIDEN NAME <b>EMMA BUTLER</b>		9. AGE (In years last birthday) <b>70</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>709-03-6168</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
17. INFORMANT <b>BALTO MD 21229</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>153.8 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of colon with metastases</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 29 1970</b> to <b>JUNE 1 1970</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JUNE 1 1970</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Dr. Gloria Boonswang</b>				23B. DATE SIGNED <b>06/01/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>GLORIA BOONSWANG, M.D.</b>				23D. ADDRESS <b>BALTO MD 21229 ST AGNES HOSPITAL, CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 4, 1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR <b>H.H. Hubbard</b>			
25D. ADDRESS <b>Funeral Home 4107 Wilkens</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5664</span>	
H-430		70 5664		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
OLIVIA W. HOLT		May 30, 1970		1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 St. Agnes Hospital Caton & Wilkens Avenue 21229			A. STATE Maryland		
			B. COUNTY Morrell Park		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1909 Whistler Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8-2-1907	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bookkeeper		W. Rae Dempsey Co.		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Alfred Jeffries			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			190-09-1277		ADDRESS 21230
18. <span style="font-size: 1.5em;">436.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH <i>Cerebral Vascular Accident</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Hypertension essential</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>9 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) <i>Rheumatoid Arthritis</i>		<i>9 years</i>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> 19 <i>49</i> to <i>5/30</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>5/15</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John P. Urlock Jr</i>				23B. DATE SIGNED <i>6/1/70</i>	
23C. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr				23D. ADDRESS 1227 Washington Blvd., Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-3-1970		Frostburg Memorial Pk. Cem., Frostburg, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 8 1970		<i>Robert E. Fisher, M.D.</i>		Howard H. Hubbard, 4107 Wilkens Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

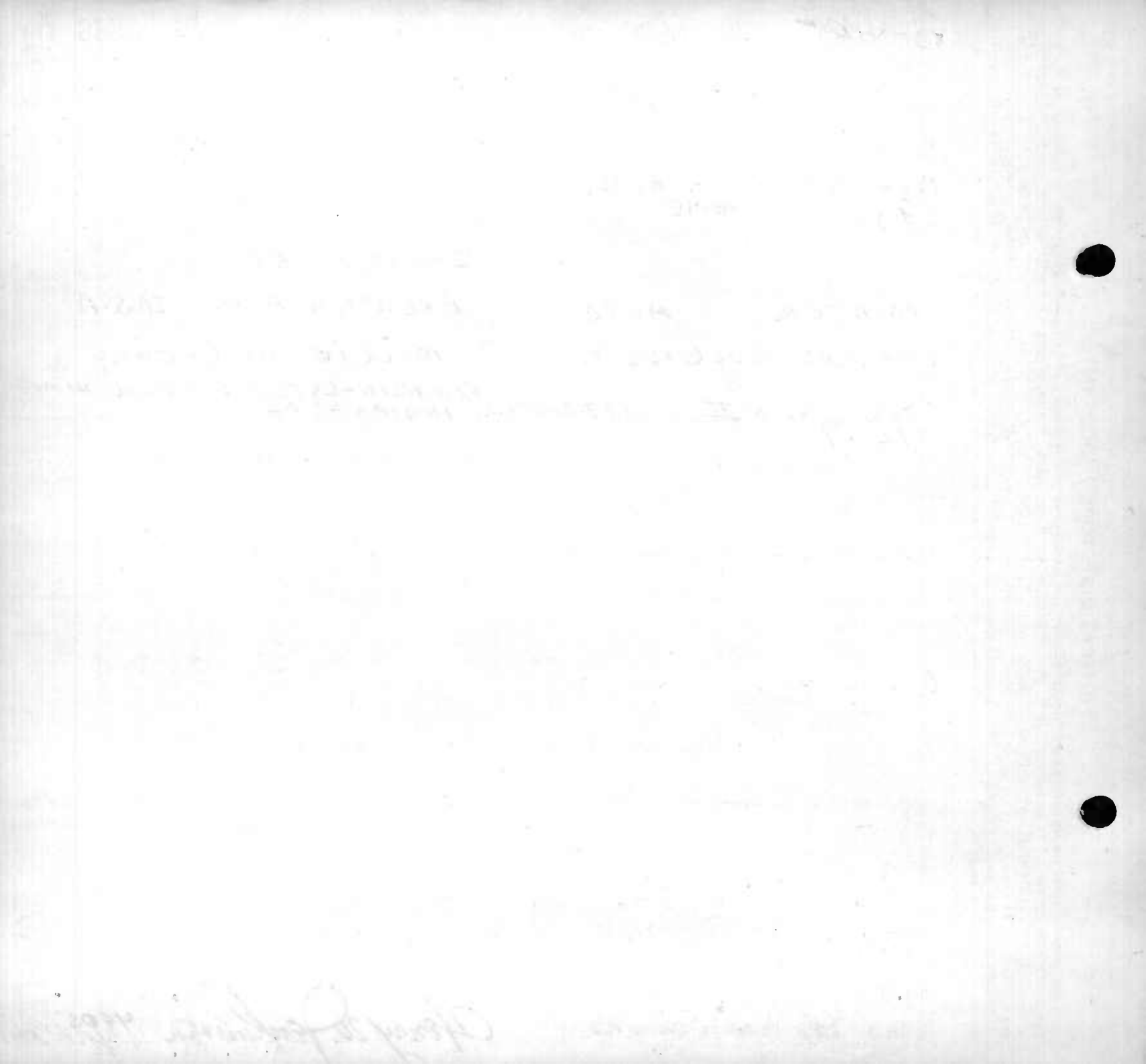
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5665</u>	
BIRTH NO. <u>S-536</u>		70 5665		CERTIFICATE OF DEATH <u>X</u>	
1. NAME OF DECEASED (Type or Print) <u>Donald J. Snyder</u>			2. DATE AND HOUR OF DEATH <u>May 31, 1970</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>294 Bloomsbury Avenue</u> ZIP: <u>21228</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/1912</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>T.V.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>John Snyder</u>			14. MOTHER'S MAIDEN NAME <u>Ella McMamer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-07-3557</u>	17. INFORMANT <u>Mrs. Dorothy Snyder</u> ADDRESS <u>21228 294 Bloomsbury Ave.</u>		
18. <u>4109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1970</u> to <u>April 23, 1970</u> that (I) (we) last saw the deceased alive on <u>April 23, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hugh G. Beebe</u>			23B. DATE SIGNED <u>June 2, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Hugh G. Beebe, M.D.</u>
23D. ADDRESS <u>827 Linden Avenue, Balto., Md. 21201</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-3-1970</u>	24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>H. Hubbard</u>		ADDRESS <u>Funeral Home 4107 Wilkens Ave.</u>

Handwritten signature

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

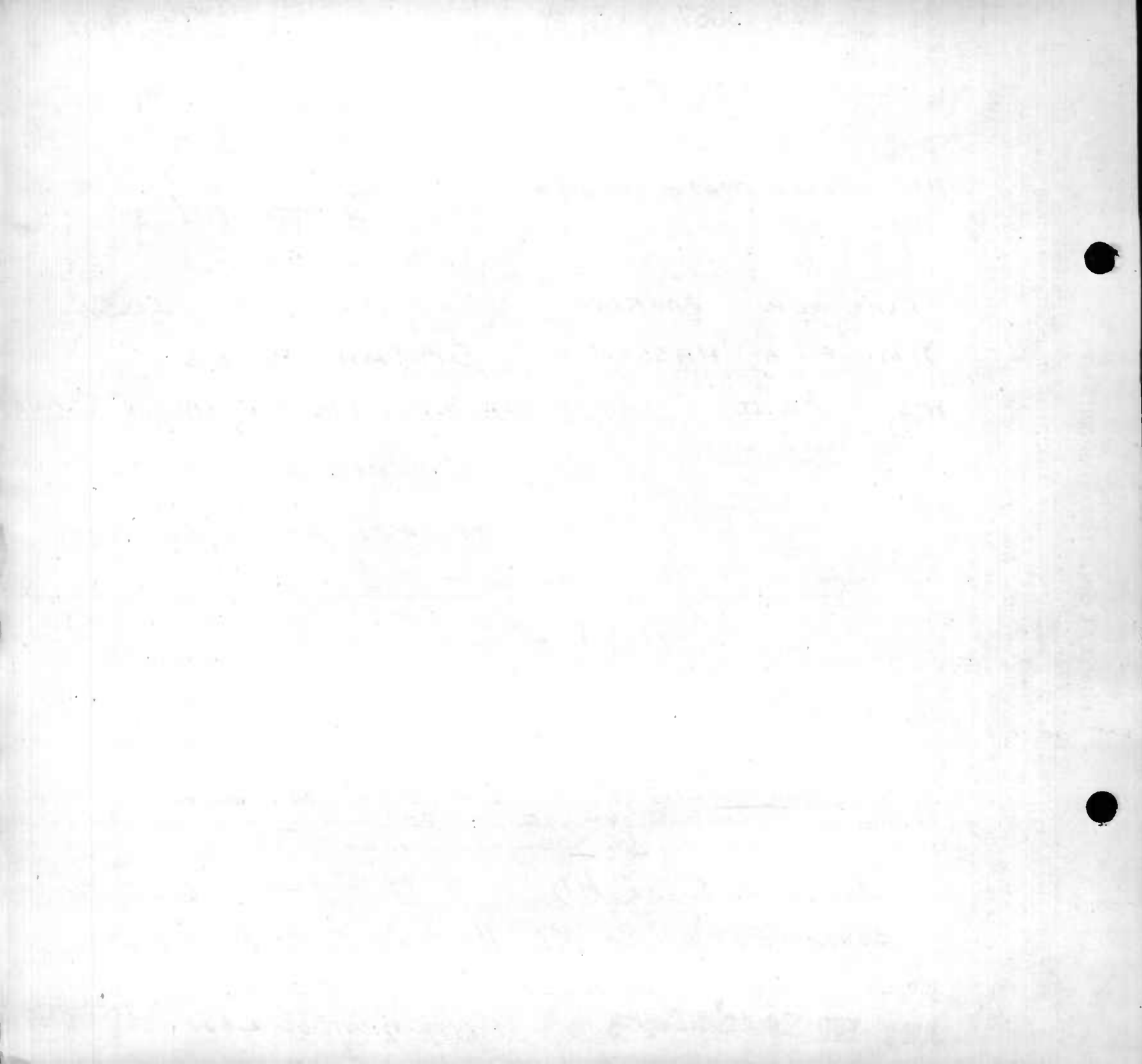
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">70 5666</span>	
C-410 70 5666		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CULLIVER, LAWRENCE DEWEY</b>		2. DATE AND HOUR OF DEATH <b>6/2/70 6:15 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>PLEASANT MAYOR NURSING HOME</b> <b>90</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>VA</b> B. COUNTY <b>VA</b> C. CITY OR TOWN <b>VAH #46 University Dr. Park Pk 15240</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>35</b> E. STREET AND NUMBER <b>5500 Fern Pl Ave Baltimore 110</b>			
5. SEX <b>M</b>	6. RACE <b>N N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-1911</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>		11. BIRTHPLACE (State or foreign country) <b>BREWTON, ALA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>CHARLES CULLIVER</b>		14. MOTHER'S MAIDEN NAME <b>MILLIE MCCREARY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>177-01-0062</b>		17. INFORMANT ADDRESS <b>ROBINSON-LYTTLE FUNERAL HOME INDIANA, PA.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma stomach &amp; metastasis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2-3-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>same</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3-7 1970</b> to <b>6-2 1970</b> , that (I) last saw the deceased alive on <b>5-27 1970</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (no) view the body after death.					
23A. SIGNATURE <b>Frank G. Kuehn</b>				23B. DATE SIGNED <b>6-2-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANK G. KUEHN</b>				23D. ADDRESS <b>721 MED ARTS BLDG. BALTO 1</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>6/5/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oakland</b>	
24D. LOCATION (City, town, or county) <b>White Township, Pa.</b>		24E. ADDRESS <b>4905 York St. Balto. Md. 21204</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 3 1970</b>		25B. NAME OF REGISTRAR <b>John E. Miller, Jr.</b>		25C. FUNERAL DIRECTOR <b>George W. Jenkins &amp; Son</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-25070 5667		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5667	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HASSON - WILLIAM F.A.		2. DATE AND HOUR OF DEATH 6-2-70 11 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY MARYLAND 21212 5300			
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE Hospital 91		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-15-99		9. AGE (In years last birthday) 71		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER		10B. KIND OF BUSINESS OR INDUSTRY BANKING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WM. F. A. HASSON		14. MOTHER'S MAIDEN NAME SARAH HARRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 217-14-1122A		17. INFORMANT MRS. IDA J. F. HASSON (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.9 I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) CEREbrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C) ASD -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days 1969 Aug & Dec	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-18 1970 to 6-2 1970, that (I) (we) lost saw the deceased alive on 6-2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sonia Estruch MD		23B. DATE SIGNED 6-2-70		23C. PHYSICIAN'S NAME (Type) Sonia Estruch MD	
23D. ADDRESS Montebello State Hosp.		23E. FUNERAL DIRECTOR Henry J. Estruch + Son		23F. ADDRESS 4905 York Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 3 1970		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 5668	
CERTIFICATE OF DEATH				REG. NO. 70 5668	
BIRTH NO. <u>S-260</u>		1. NAME OF DECEASED (Type or Print) <u>SCHWEIGER, CHARLES J.</u>		2. DATE AND HOUR OF DEATH <u>6.1.70 10<sup>30</sup> AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>903</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL / BALTO</u>		C. CITY OR TOWN <u>BALTIMORE 21218</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3723 DELVERNE RD.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1.30.96</u>	9. AGE (in years less birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SERVICE STATION BALTO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN SCHWEIGER</u>			
14. MOTHER'S MAIDEN NAME <u>JENNIE DEINLEIN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>YES</u> <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>213-10-3784</u>		17. INFORMANT <u>MRS. JOHN C. BICKEL</u> ADDRESS <u>3815 REXMERE RD.</u>			
18. <u>444.19 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>MULTIPLE PULMONARY EMBOLI</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>AND/OR MYOCARDIAL INFARCTION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ACUTE</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 weeks.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ASCVD.</u>		Years. <u>Years.</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(4)</u> (this hospital) attended the deceased from <u>5.21.70</u> 19____ to <u>6.1.70</u> 19____ that <u>(4)</u> (we) last saw the deceased alive on <u>6.1.70</u> 19____ and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(4)</u> (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>M. Bodenheimer, M.D.</u>				23B. DATE SIGNED <u>6.1.70</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. BODENHEIMER M.D.</u>				23D. ADDRESS <u>Sinai Hospital, Staff</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-5-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 3 1970</u>			
25B. NAME OF REGISTRAR <u>Jacob E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins, Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>			

Burial 16-5-70 Holy Redeemer Cem. Baltimore, Md.  
H.W. Jenkins Sons Co. 4905 York Rd.  
Baltimore, Md. 21212

Sinai Hospital, Staff

Yes

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-200 70 - 5669		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 63-18516		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
KEVIN D. COOK		1 June 70 6:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND B. COUNTY 804	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2236 E. Chase St	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-11-63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 6	11. BIRTHPLACE (State or foreign country) Maryland
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM COOK		14. MOTHER'S MAIDEN NAME BERNICE ELLIOT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Bernice Dawson 2236 E. Chase Street
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Cranio-cerebral Injuries (A) IMMEDIATE CAUSE Brainstem decomposition DUE TO, OR AS A CONSEQUENCE OF: (B) Crushed skull fracture DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr. 72 hr.			
19A. DATE OF OPERATION 7/0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balt. City. Chase & Patterson Pk. Ave.		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) MAY 29 1970 6:00	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. struck by automobile	
22. I certify that (1) (this hospital) attended the deceased from 29 May 1970 to 1 June 1970 that (1) (we) last saw the deceased alive on 1 June 1970 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lawrence J. Jelsma		23B. DATE SIGNED 1 June 70	
23C. PHYSICIAN'S NAME (Type) LAWRENCE JELSMA		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/70	
24C. NAME OF CEMETERY or CREMATORY Balto National Cem		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1970		25B. NAME OF REGISTRAR Wm C March	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

2236 E. Chase St.

1  
M-525

70 5670

BALTIMORE CITY HEALTH DEPARTMENT

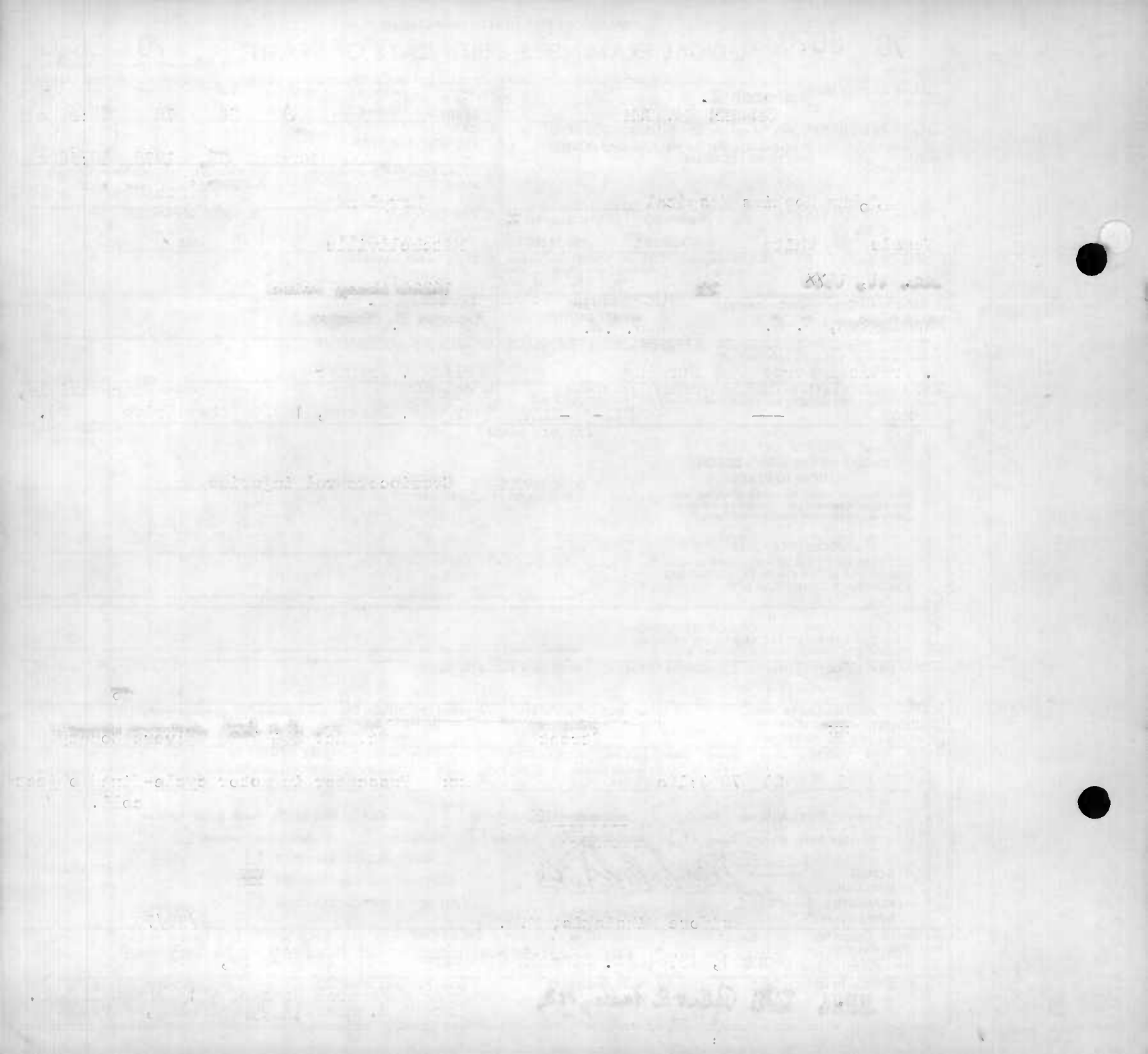
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5670

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Deborah S. DEBBIE MANGUM</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 28 70 10:58 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour May 28 1970 10:58 a.m.	
6. SEX <u>Female</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Mitchellville</u>	
9. DATE OF BIRTH <u>Dec. 11, 1977</u>		10. AGE (In years lost birthday) <u>21</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>L. Pratical Nurse</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>212-54-2874</u>	
15. MOTHER'S MAIDEN NAME <u>Della S. Crander</u>		18. INFORMANT <u>George E. Mangum, 16320 Abbey Drive Md.</u>	
19. <u>E 815.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Craniocerebral injuries</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <u>5/29/70</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>St. Rt. 2 &amp; 402 Calvert County</u>		22D. TIME OF INJURY (APPROX.) <u>5 24 70 4:16am</u>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Passenger in motor cycle-fixed object coll.</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 1, 1970</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Robert G. Beall</u>		ADDRESS <u>9013 Annapolis Rd. Lanham, Maryland</u>	



70 5671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5671

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James, Shelton

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

11:58 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1002

6. SEX

male

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

7

10. AGE (In years  
last birthday)

59

11. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1301 E. Eager St.

11. BIRTHPLACE (State or foreign country)

Orangeburg SC.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Mackie James

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Annie Isaac

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

217-40-3638

18. INFORMANT

ADDRESS

Ara Beel Howard (Sister)

19.

E966X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stab wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

900 Blk. Central Ave.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

5 29 70 5:00 p.m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

stabbed during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner

5/30/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/3/70

24C. NAME OF CEMETERY or CREMATORY

Harmony M. Cem.

24D. LOCATION (City, town, or county) (State)

7601 Sheriff Rd., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 4 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

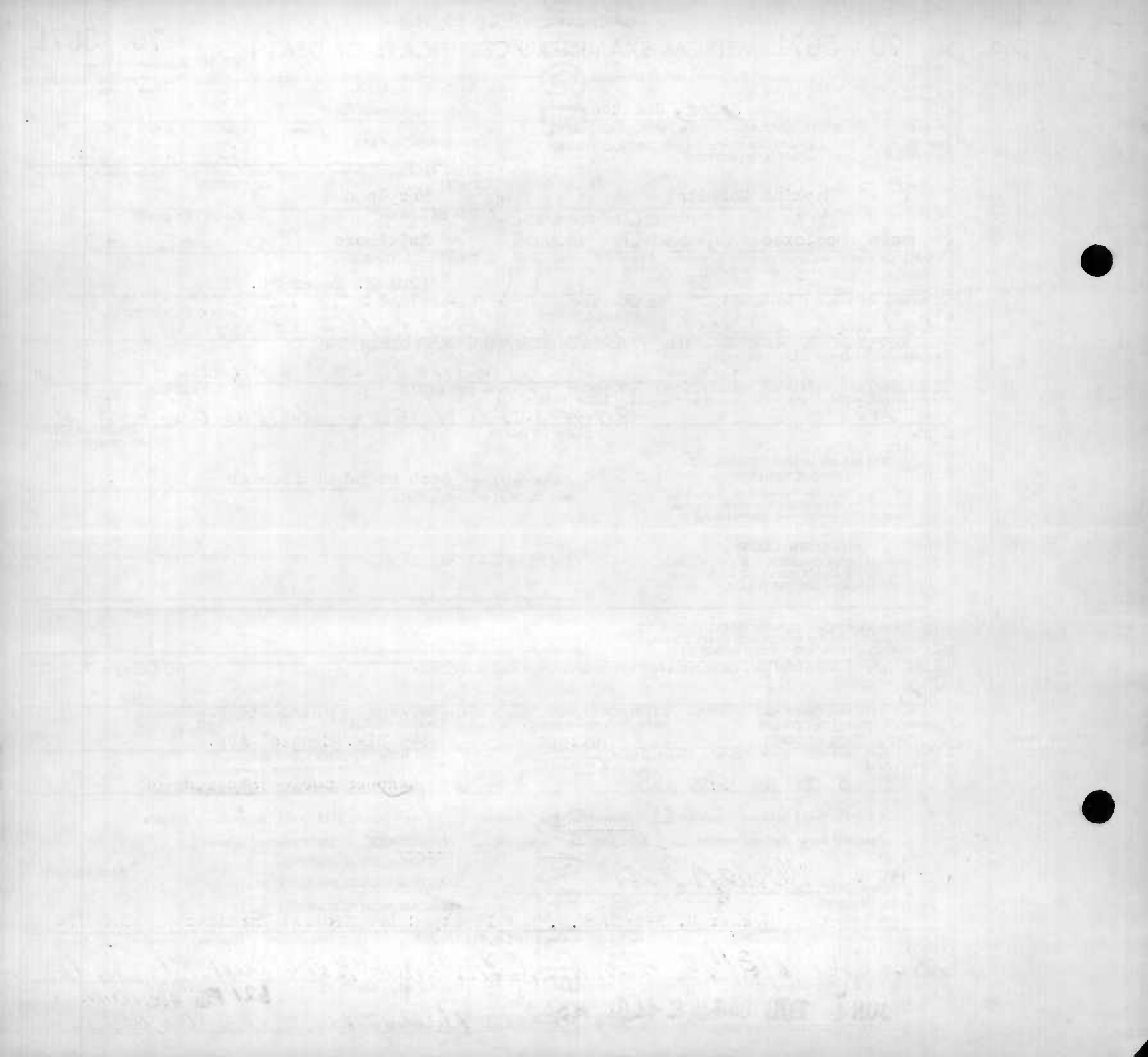
25C. FUNERAL DIRECTOR

Hall Bros - Wash., D.C.

ADDRESS

621 Fla. Ave., N.W.



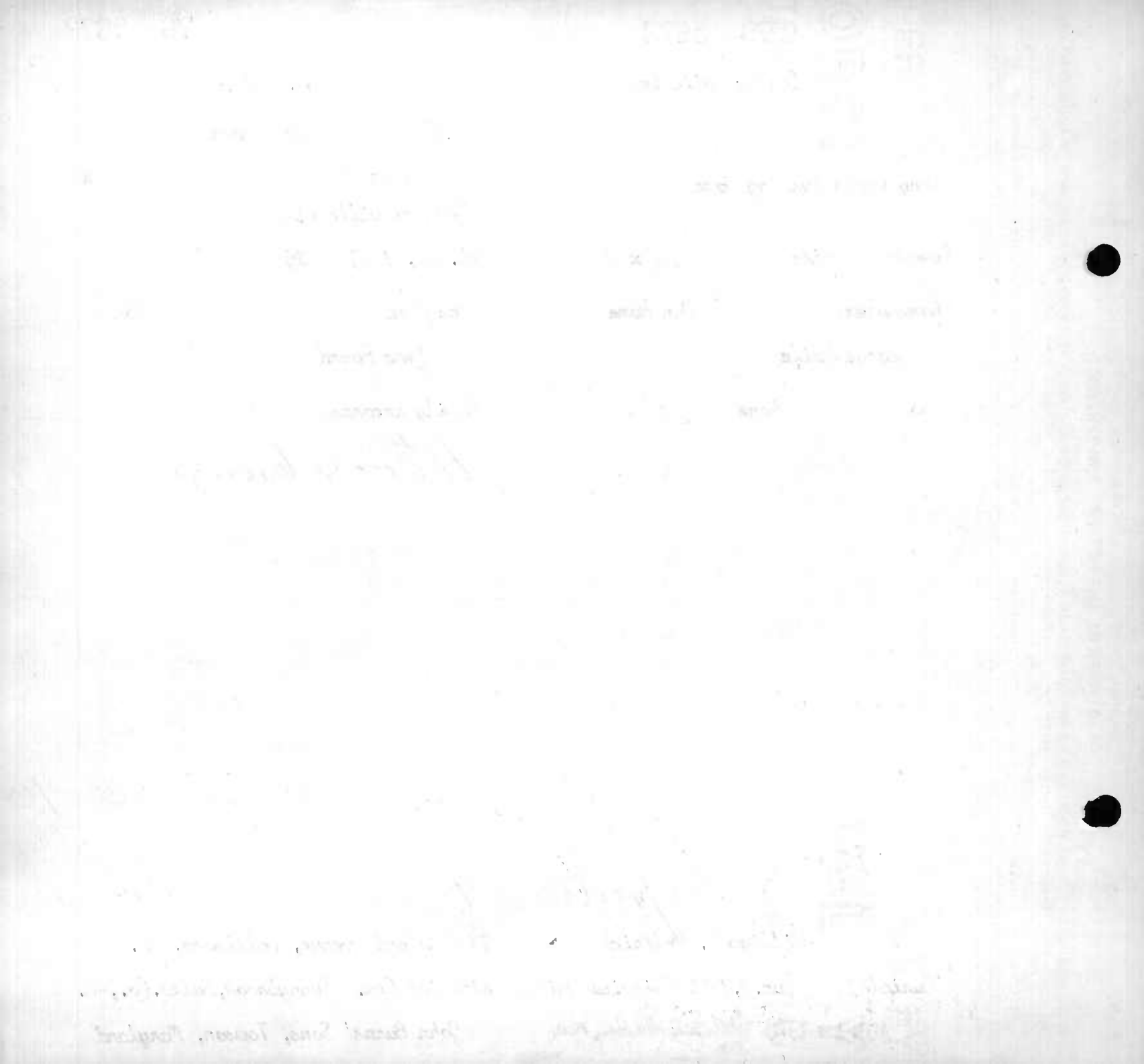




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5672</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5672</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Bertha Haile Lee</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">May 30, 1970</span> <span style="font-size: 1.5em;">4:00 P</span> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Long Green Nursing Home</span> <span style="font-size: 1.5em;">90</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="font-size: 1.5em;">53-00</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">Sunnybrook</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">Jarrettsville Pike</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Feb. 22, 1885</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">85</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Own Home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">George Haile</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Foard</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span> <span style="font-size: 1.2em;">None</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Family records</span>	
18. <span style="font-size: 1.5em;">440.9.1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Tuberculosis</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Feb 19 66</span> to <span style="font-size: 1.5em;">May 30 19 70</span> and that in (my) <span style="font-size: 1.5em;">my</span> opinion death occurred on the date and hour and from the causes stated above. (I) <span style="font-size: 1.5em;">did</span> (did not) view the body after death.					
23A. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">W. G. Helfrich</span> <span style="font-size: 1.2em;">William G. Helfrich</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">1 June 70</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Jun. 3, 1970</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Fairview United Methodist Cem.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 4 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, R.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">John Burns' Sons, Towson, Maryland</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Sunnybrook, Balto. Co., Md.</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 5673</b>	
BIRTH NO. <b>10-8921 70 5673</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>DARREN W. MASUCCI</b>		2. DATE AND HOUR OF DEATH <b>6-2-70 6:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> ADDRESS OR LOCATION <b>6-16-70</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>702</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>637 N. BELNORD AVE.</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>1 6</b>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>LOUIS MASUCCI</b>		14. MOTHER'S MAIDEN NAME <b>Hilseberg CAROLYN HILSEBERG</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Louis Masucci, father, above</b>
18. <b>746.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>cardiac arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>hypoplastic left heart syndrome</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-2-70</b> to <b>6-2-70</b> that (I) (we) last saw the deceased alive on <b>6-2-70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James H. Sightler, M.D.</b> DEGREE <b>M.D.</b> Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>6-2-70</b>
23C. PHYSICIAN'S NAME (Type) <b>JAMES H. SIGHTLER</b>			
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/3/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> ADDRESS <b>3331 Brehms Lane</b>

Corrected by B.C. 70-8921 6-16-70 M.H.

S-351

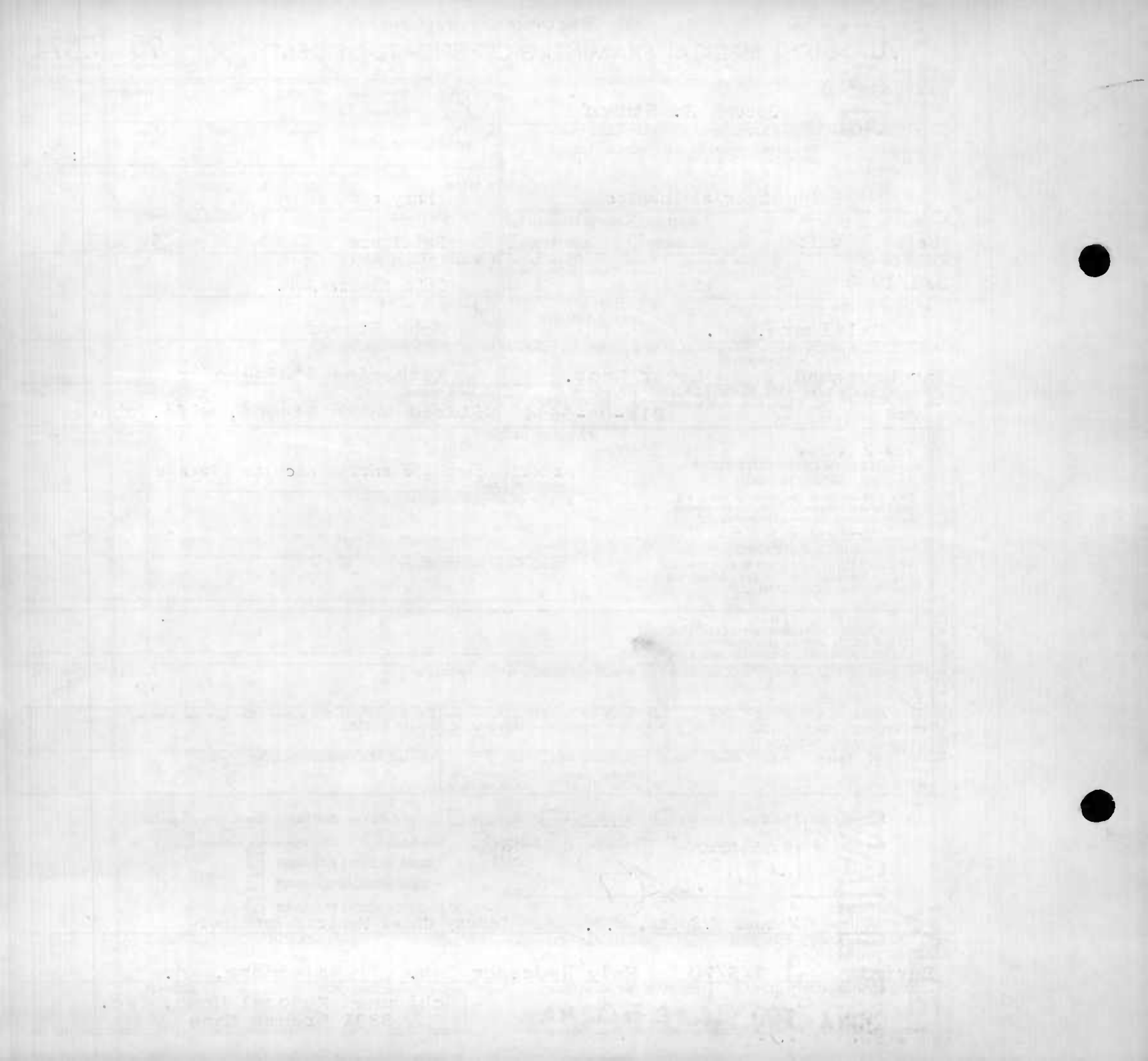
## BALTIMORE CITY HEALTH DEPARTMENT

70 5674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5674

BIRTH NO.

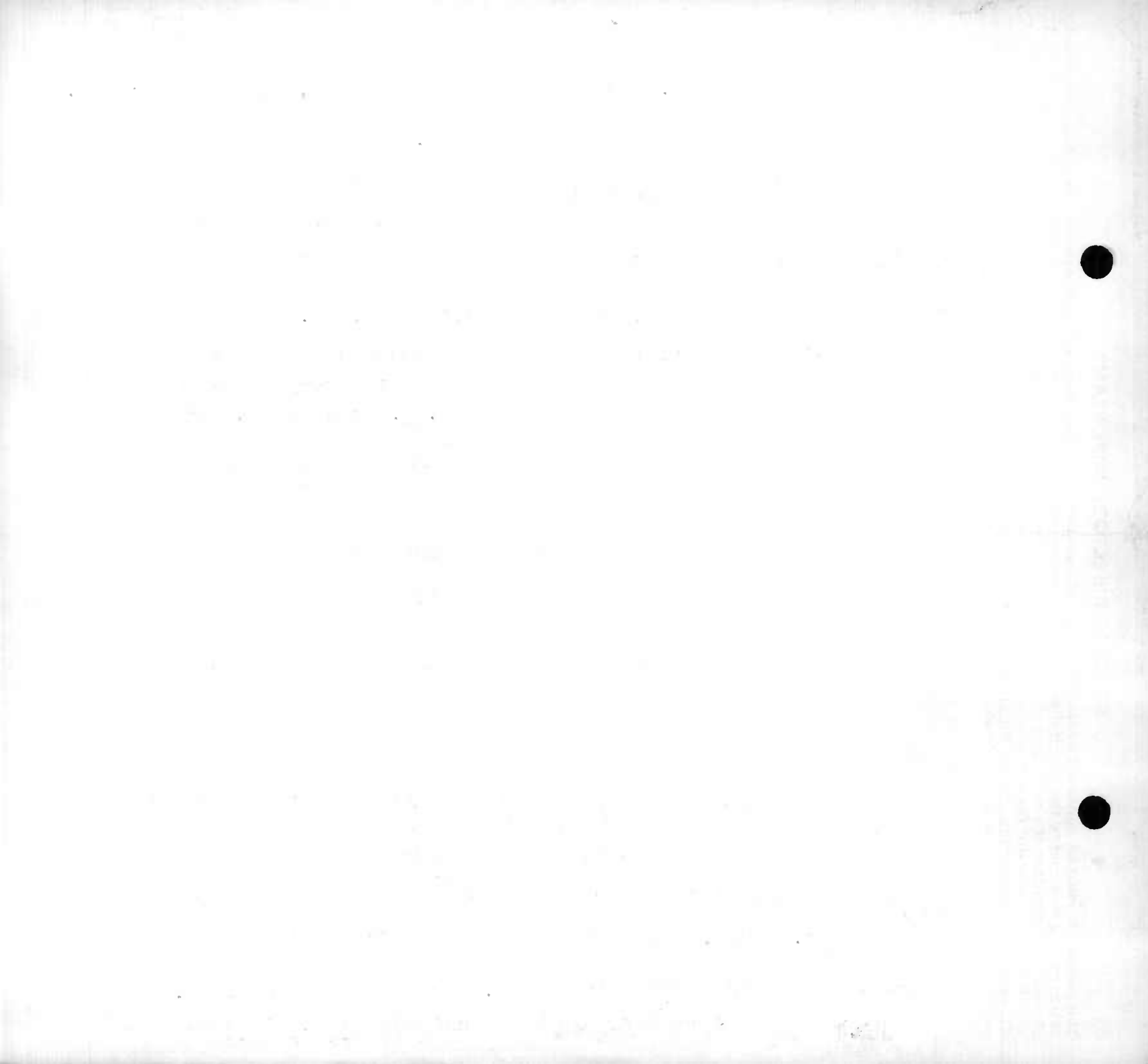
1. NAME OF DECEASED (Type or Print) <b>Joseph J. Stumpf</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 1 70 10:45a</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 1 70 10:45a</b> M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3/1/1908</b>		10. AGE (In years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>John Stumpf</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>		15. MOTHER'S MAIDEN NAME <b>Katherine Steinehofer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes WW 2</b>		17. SOCIAL SECURITY NO. <b>218-05-5554</b>	
18. INFORMANT <b>Mildred Welsh Stumpf, wife, above</b>		ADDRESS <b>3626 Elmora Ave.</b>	
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>6/2/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>6 1 70 10:45a</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>NO</b>		21. AUTOPSY? (Yes or No) <b>NO</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> Deputy Chief Medical Examiner		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/2/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/5/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5675</u>	
BIRTH NO. <u>70 5675</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MOLLIE C. HOWARD</b>			2. DATE AND HOUR OF DEATH <b>May 30, 1970 9:10 a. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2741</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3510 Southern Avenue</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/82</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Alexander Mentzel</b>			14. MOTHER'S MAIDEN NAME <b>Roseanna McCusker</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>3136 Harford Road</b> ADDRESS <b>Mrs. H. Larue Parke, atty</b>
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			CAUSE OF DEATH <b>Arteriosclerotic Cardio-vascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Years</b>
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 25</b> 19 <b>70</b> to <b>May 29</b> 19 <b>70</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 29</b> 19 <b>70</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Dr. Loy M. Zimmerman M.D.</b>				23B. DATE SIGNED <b>6/2/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Loy M. Zimmerman</b>				23D. ADDRESS <b>3202 Harford Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
				ADDRESS <b>3331 Brehms Lane</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5676	
BIRTH NO. 70 5676		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PHILIP D. WACHTEL, Sr.		2. DATE AND HOUR OF DEATH May 30, 1970 2 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 500 West University Pkwy.			
5. SEX male	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1877	9. AGE (In years lost birthday) 92	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman, retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Wachtel		14. MOTHER'S MAIDEN NAME Jeannette Kohn		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 092-07-2376A		17. INFORMANT Mr. Philip D. Wachtel, Jr.		ADDRESS (Same)	
18. I 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH Atherosclerosis (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 3 1968 to May 30 1970 that (I) (we) last saw the deceased alive on May 23 1970 and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. William Helfrich MD		23B. DATE SIGNED 1 June 70		23C. PHYSICIAN'S NAME (Type) Dr. William Helfrich	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6/2/70.		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Baltimore, Md.		25D. ADDRESS		25E. ADDRESS	

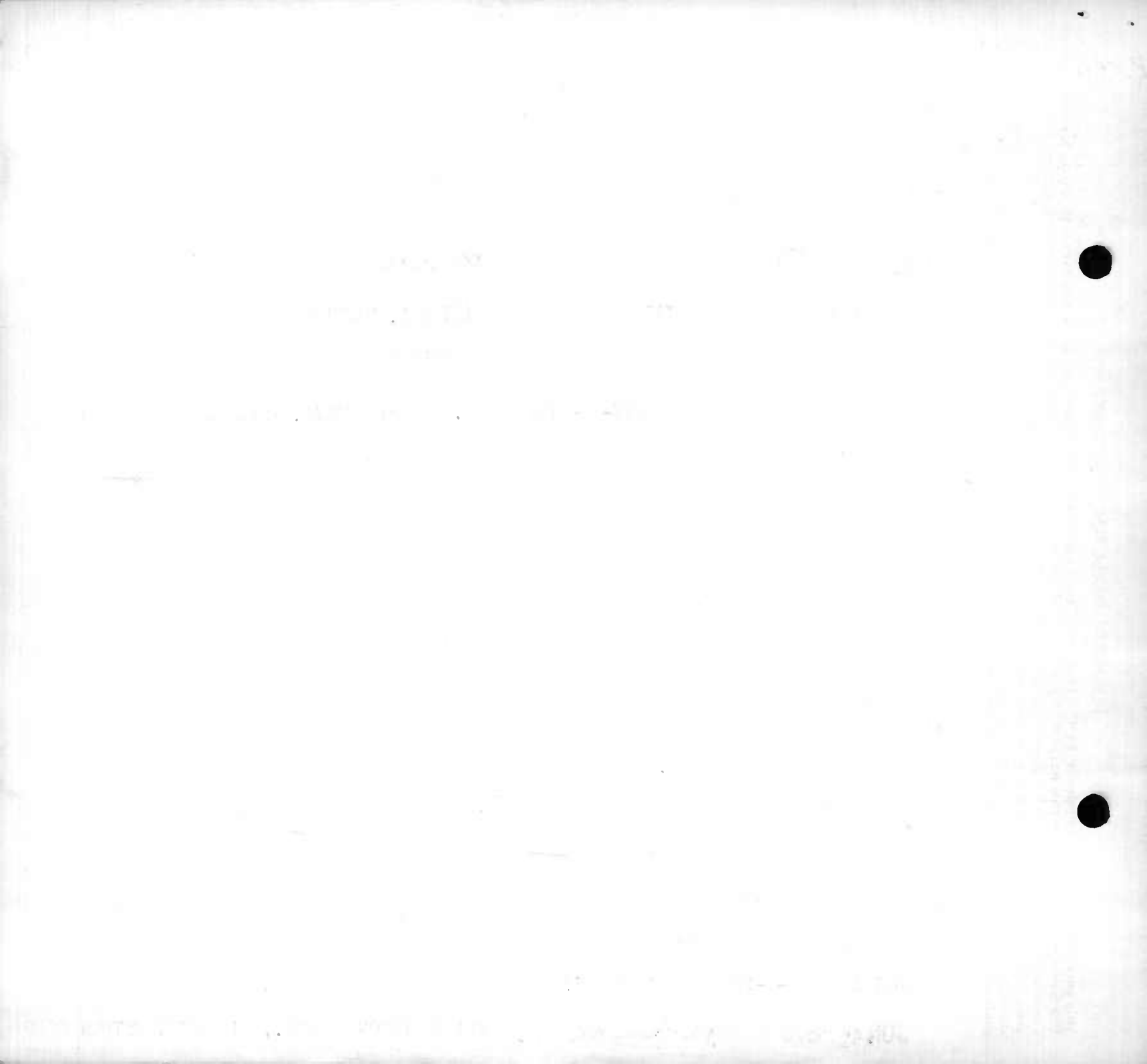
Chlorophyll

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

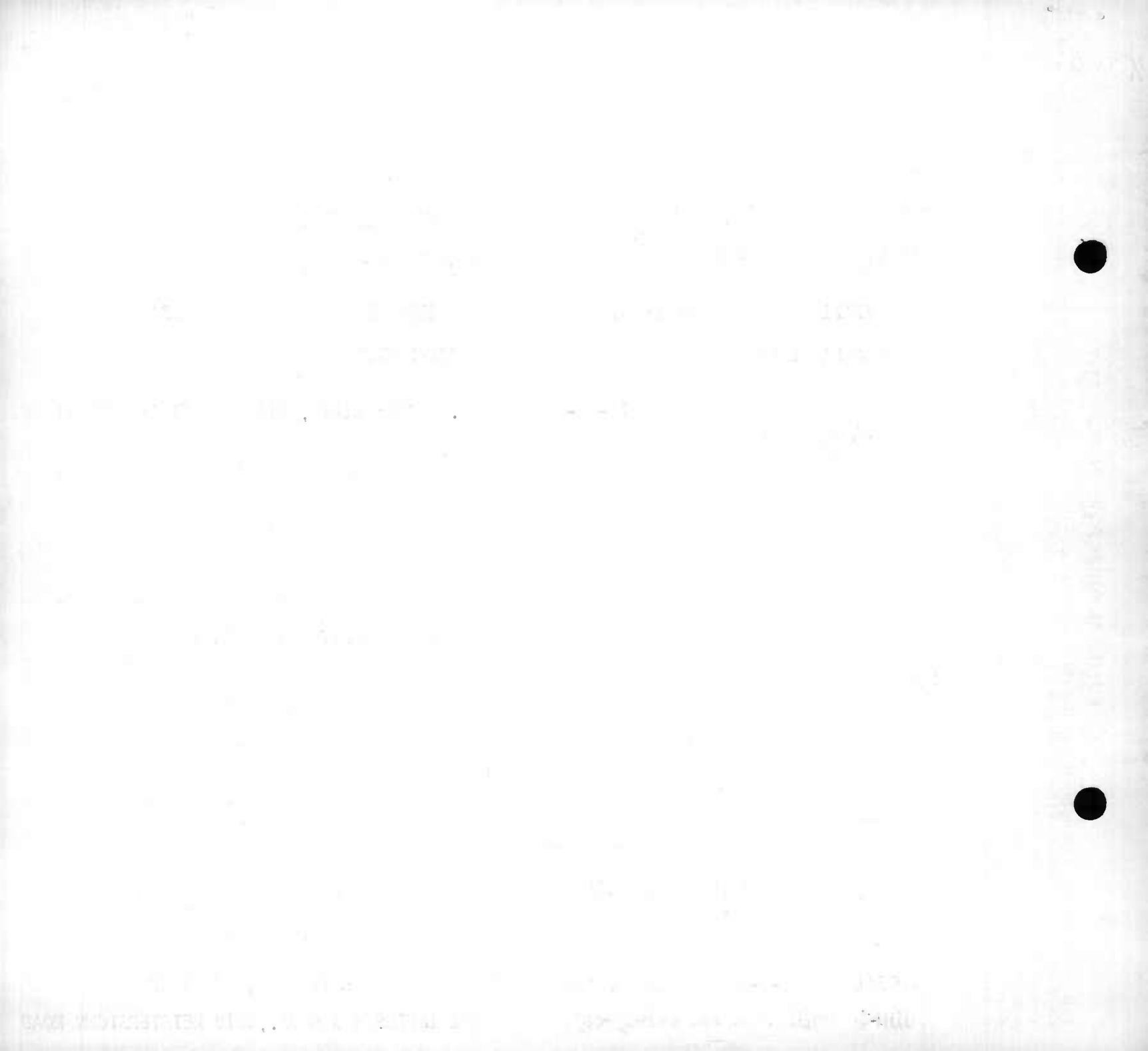
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 5677	
BIRTH NO. 70 5677		1. NAME OF DECEASED (Type or Print) KAHN, HARRY EDWARD		2. DATE AND HOUR OF DEATH 6-1-70 10 <sup>35</sup> PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL BALTIMORE 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND BALLO		B. COUNTY 5300	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		E. STREET AND NUMBER 8313 Stevenson Rd.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME ? KAHN		14. MOTHER'S MAIDEN NAME UNKNOWN		8. DATE OF BIRTH 8/28/1904		9. AGE (In years last birthday) 76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-6157		17. INFORMANT MRS. SAMUEL MARKIN, 8313 STEVENSON ROAD		ADDRESS	
18. 412.4 + 1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		Years.	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				DIABETES MELLITUS		Years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 5-30-70 19 to 6-1-70 19 that (1) (we) last saw the deceased alive on 6-1-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Bodenheim M.D.				23B. DATE SIGNED 6-1-70			
23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER, M.D.				23D. ADDRESS Sinai			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-3-70		24C. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 5678		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5678	
1. NAME OF DECEASED (Type or Print) <b>JACOB KLEIN</b>		2. DATE AND HOUR OF DEATH <b>6/2/70 2:30 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7112 DEERFIELD ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/38</b>	9. AGE (In years last birthday) <b>32</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL KLEIN</b>			
14. MOTHER'S MAIDEN NAME <b>SARAH STERN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>212-09-5609A</b>		17. INFORMANT ADDRESS <b>MRS. NETTIE KLEIN, 7112 DEERFIELD ROAD #21208</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident. 2 weeks</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>Congestive heart failure</b>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Congestive heart failure</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/19/70</b> to <b>6/2/70</b> 19 <b>70</b> and that (I) <del>was</del> last saw the deceased alive on <b>6/2/70</b> 19 <b>70</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>D. D. Gaynor</b>		23B. DATE SIGNED <b>6/2/70</b>		23C. PHYSICIAN'S NAME (Type) <b>DONAL D. GAYNOR MD</b>	
23D. ADDRESS <b>Sinai Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>6-3-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BETH ISAAC ADAS ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Sol Levinson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5679</span>	
30 5679				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>MILTON PROSER</u>		<div style="display: flex; justify-content: space-between;"> <span><u>JUNE 2, 1970</u></span> <span><u>8:10 A.</u> M.</span> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42</u>			A. STATE <u>MARYLAND</u>		
			B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4007 FORDLEIGH ROAD, APT. A</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1913</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCK CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SAMUEL PROSER</u>			14. MOTHER'S MAIDEN NAME <u>EDITH COHEN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W II</u>		16. SOCIAL SECURITY NO. <u>214-01-8623</u>	17. INFORMANT <u>MRS. IRENE PROSER, X 4007 FORDLEIGH RD., APT. A</u>		
18. <u>433,91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Acute Central Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Central Thrombosis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Central Thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>6 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/1/70</u> 19 <u>63</u> to <u>6/1/70</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/1/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <u>Milton Kirsh</u>			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> DEGREE		23B. DATE SIGNED <u>6/2/70</u>
23C. PHYSICIAN'S NAME (Type) <u>MILTON KIRSH</u>			23D. ADDRESS <u>4000 W. NORTHERN PKWY.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-3-70</u>	24C. NAME OF CEMETERY or CREMATORY <u>ANSHE EMUNAH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

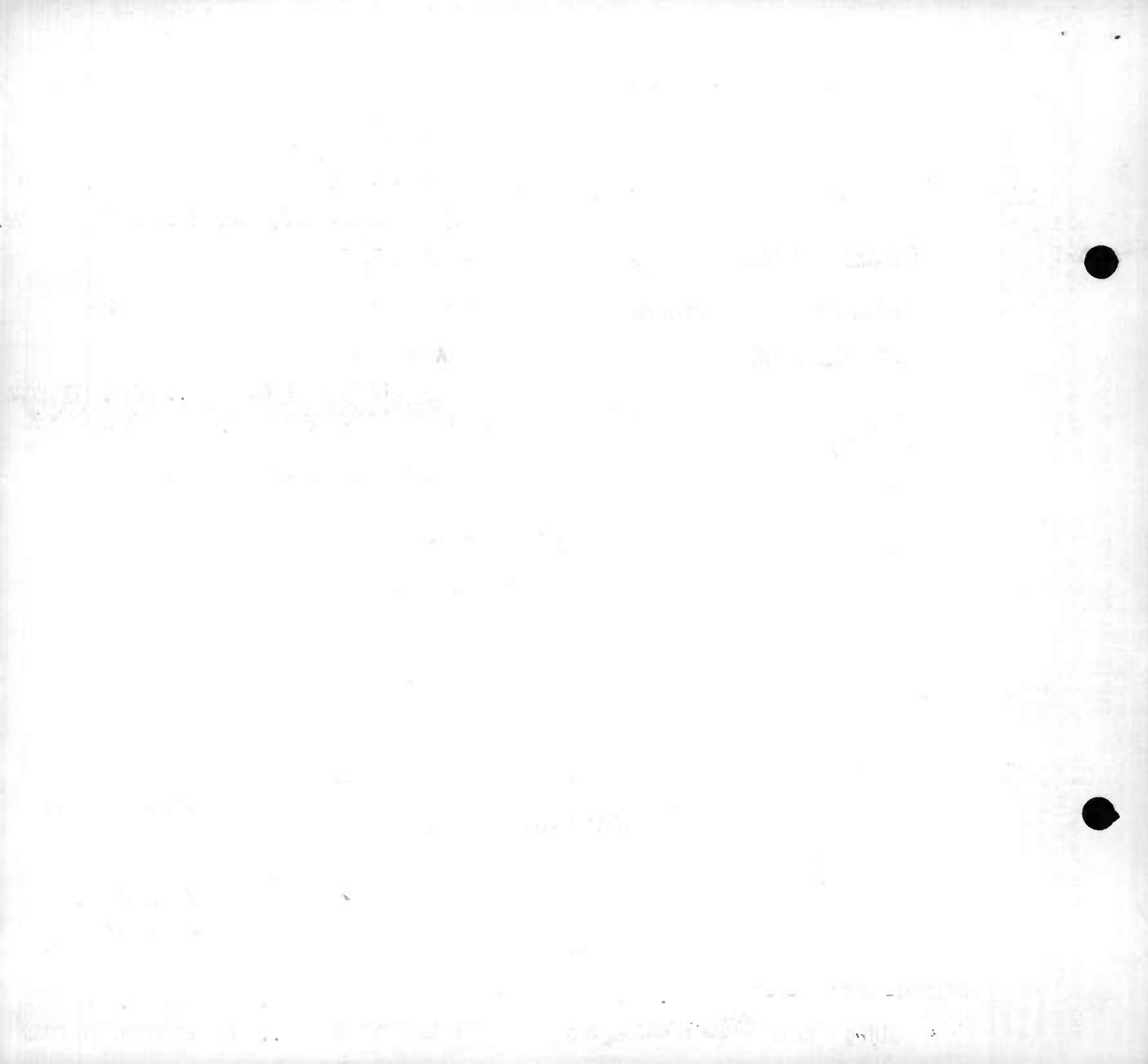




FUNERAL DIRECTOR: IMPORTANT

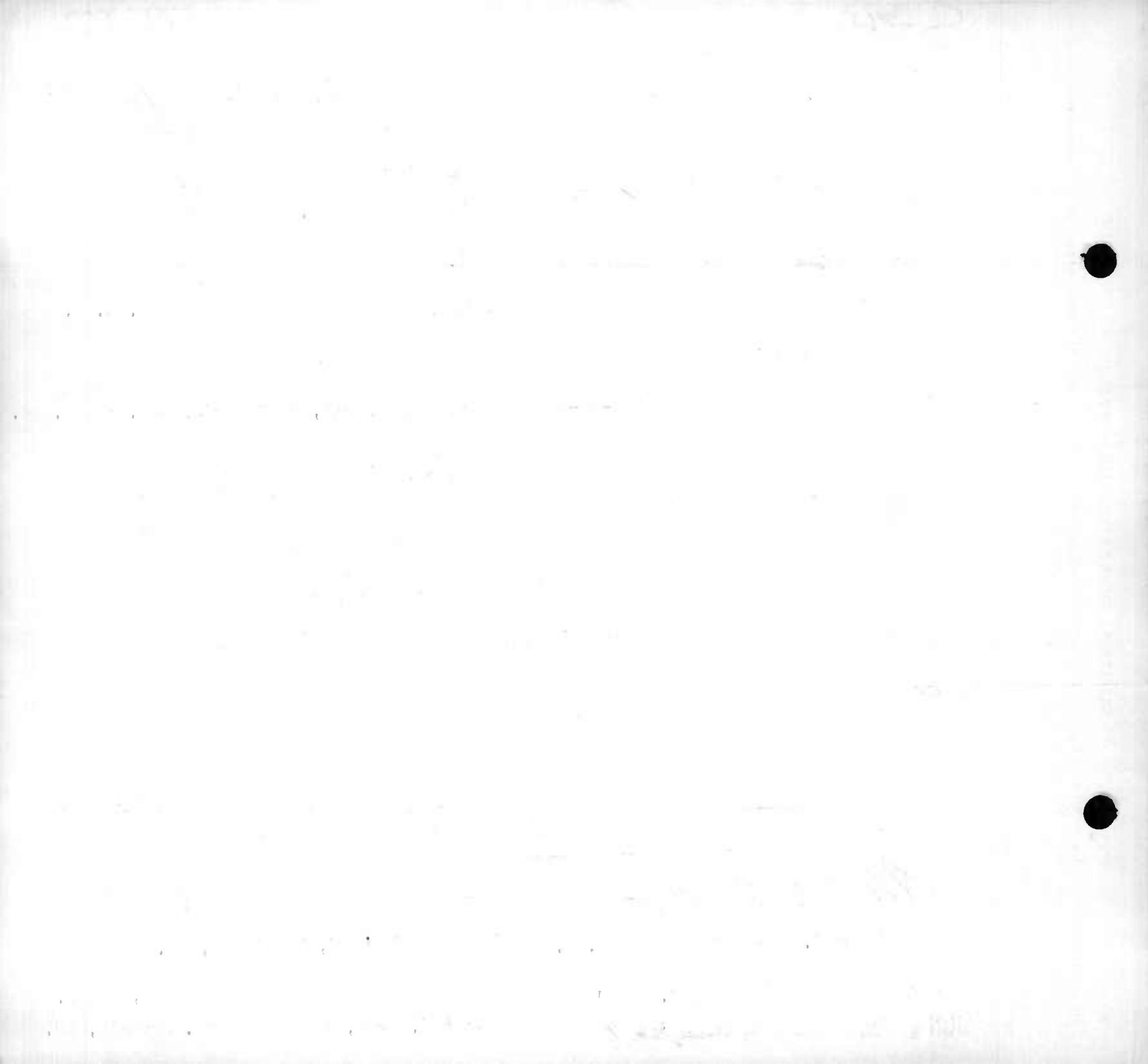
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5680		X		REG. NO. 70 5680	
BIRTH NO.				70 5680		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) <b>FEINLAND, RAE.</b>				2. DATE AND HOUR OF DEATH <b>6/2/70 245 p.m.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>43 Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>NEW YORK</b> B. COUNTY <b>V-29</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>8 Baltimore General Hospital</b>				C. CITY OR TOWN <b>BRONX</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>1030 BOYINGTON AVE</b>									
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-12-1900</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Tr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>SIGMUND ROSENBAUM</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>082-12-3078A</b>		17. INFORMANT <b>312 CONEY ISLAND AVE. BRONX, NEW YORK</b> <b>BOULEVARD FUNERAL CHAPEL</b>					
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last). <b>UREMIA.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) <b>DIABETES.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>5/15/70</b> 19 <b>70</b> to <b>6/2/70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/2/70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/2/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ESPINOZA MD</b>				23D. ADDRESS <b>3001 S. Hanover St. Balto MD</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>		24B. DATE <b>6-3-70</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. GOLDA</b>		24D. LOCATION (City, town, or county) (State) <b>HUNTINGTON, LONG ISLAND, NEW YORK</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>E. Fisher, MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

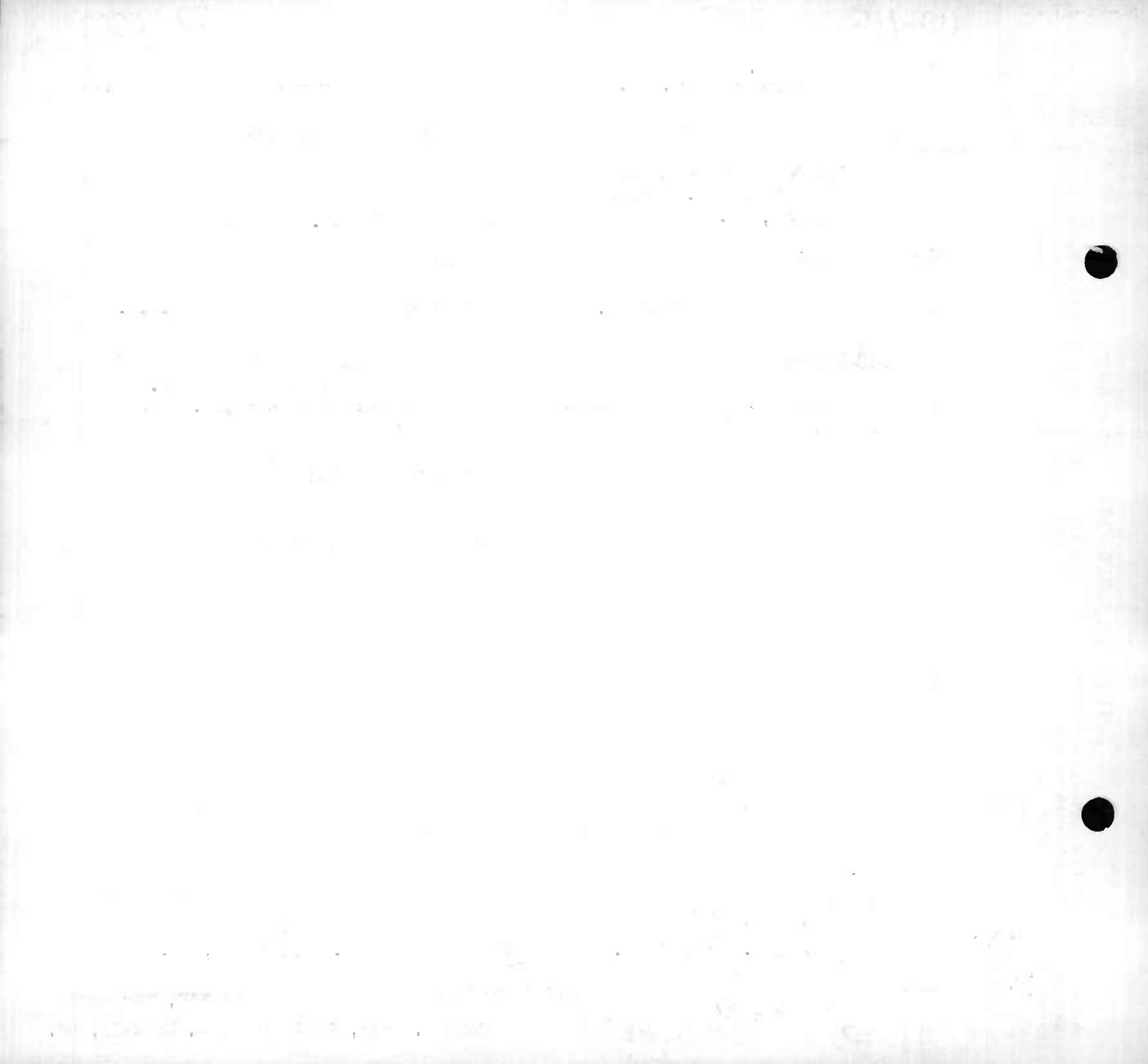
S-360 70 5681		BALTIMORE CITY HEALTH DEPARTMENT		70 5681	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
VERNA SEDAR		6/2/70 10:27A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 2636	
90 House in the Pines Belair		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1400 Anglesa St.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/94	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Nork		14. MOTHER'S MAIDEN NAME ? ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-54-5357		17. INFORMANT (Daughter) Miss Helen Sedar, 1400 Anglesa St. Balto. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 159X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Circulatory Collapse (B) Metastatic Carcinoma of Liver (C) Adenocarcinoma of Digestive Tract		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours > 3 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Gastric Ulcer; Chronic Arteriosclerosis		Unkown.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 2/21/70 to 6/2/70 that (I) (we) last saw the deceased alive on 5/27/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 6/2/70		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/70		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
24D. LOCATION (City, town, or county) (State) Kulpmount, Penna.		25A. DATE RECD BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR John E. Taylor, R.D.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25D. ADDRESS		25E. ADDRESS	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-416 70 5682</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH <u>X</u> REG. NO. <u>70 5682</u>	
1. NAME OF DECEASED (Type or Print) <u>A. Perry Wilburn, Sr.</u>		2. DATE AND HOUR OF DEATH <u>6-2-70</u> <u>4:20</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. 21224</u> <u>Baltimore, Md. 21224</u>		C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-10</u> 9. AGE (In years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roll Setter Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ora Wilburn</u>		14. MOTHER'S MAIDEN NAME <u>Rose Jeffries</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Not War time</u>		16. SOCIAL SECURITY NO. <u>213-07-2060</u>	
17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>36 hrs</u>			
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>6-1</u> 19 <u>70</u> to <u>6-2</u> 19 <u>70</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>6-2</u> 19 <u>70</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.			
23A. SIGNATURE <u>John R. Brechtel Md.</u>		23B. DATE SIGNED <u>6-2-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>John R. Brechtel Md.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/5/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor Md.</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 5683		BALTIMORE CITY HEALTH DEPARTMENT		70 5683	
W-160 70 5683		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED <b>WEBER, NORMA ELIZABETH</b>		2. DATE AND HOUR OF DEATH <b>JUNE 1, 1970 6:12 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVENUES BALTIMORE MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL COUNTY</b>			
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03 13 14</b> 9. AGE (In years last birthday) <b>56</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM HORLICKER</b>		14. MOTHER'S MAIDEN NAME <b>Mary Disney</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
18. <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>cerebral edema, cerebral softening</b> DUE TO, OR AS A CONSEQUENCE OF: <b>st. temporo-parietal lobe</b> (B) <b>st. internal carotid art. - hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>MAY 27</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>craniotomy - clipping cerebral aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>MAY 19, 1970</b> to <b>JUNE 1, 1970</b> that (X) (we) last saw the deceased alive on <b>JUNE 1, 1970</b> and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) (X) view the body after death.					
23A. SIGNATURE <b>Tse-Shiung Wu</b>		23B. DATE SIGNED <b>JUNE 1, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>TSE-SHIUNG WU</b>	
23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>6-4-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie - Md.</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Wolfe FH 130 E East ave.</b>	

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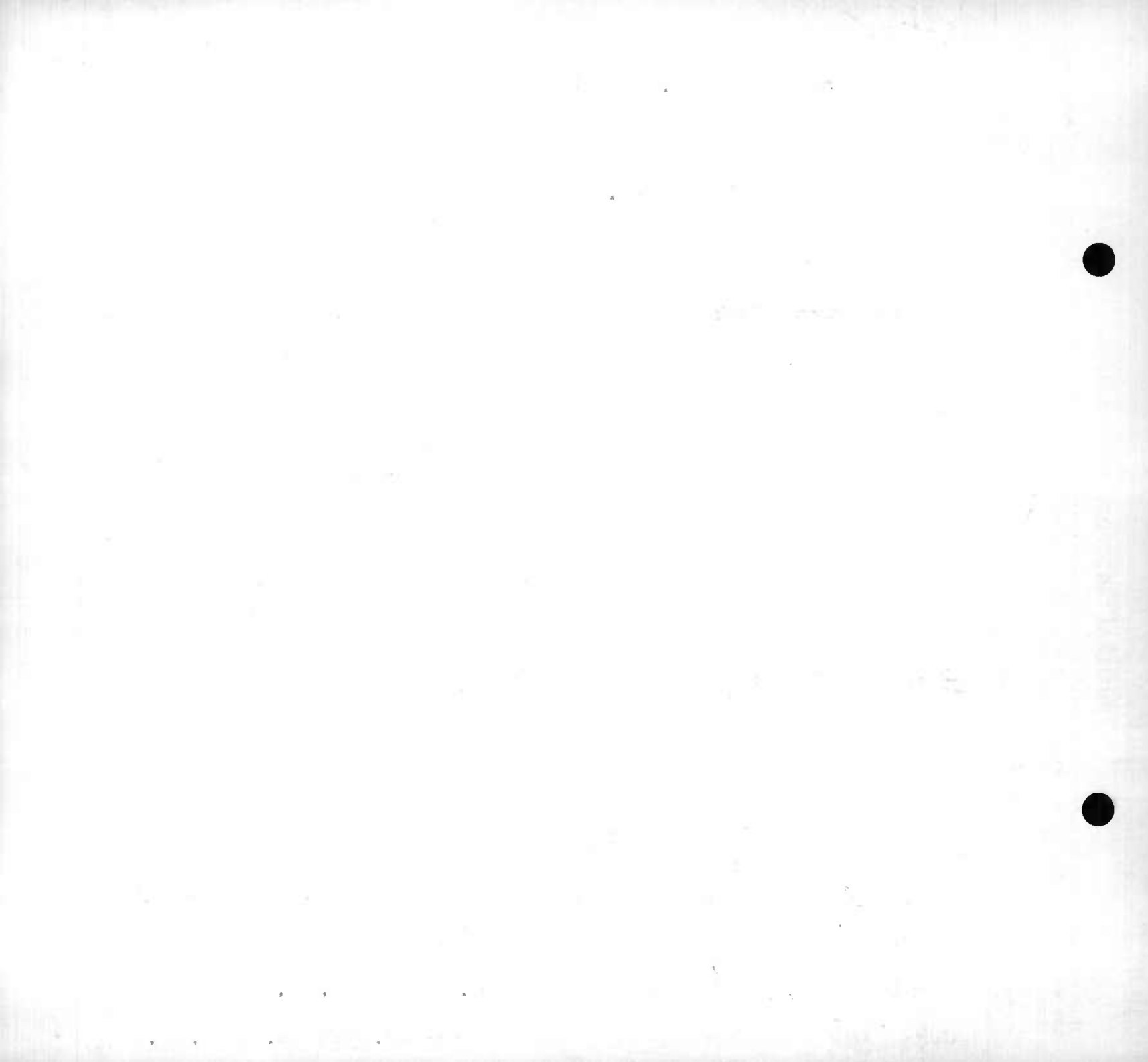
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

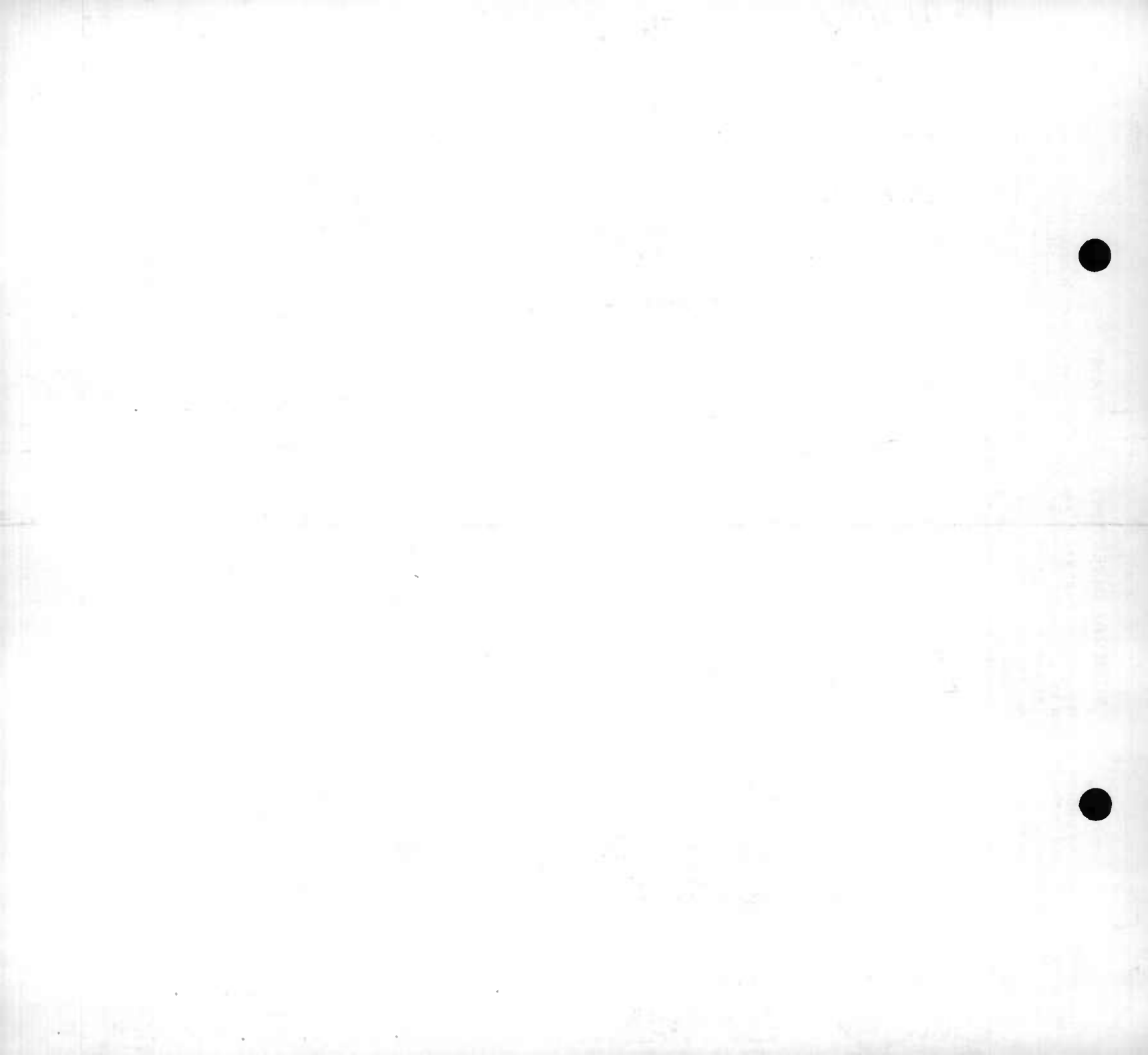
BIRTH NO. <u>K-524</u> <u>70 5684</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5684</u>	
1. NAME OF DECEASED (Type or Print) <u>Richard G. Knachel</u>				2. DATE AND HOUR OF DEATH <u>6/1/70 1:10 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2805 Evergreen Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/27/06</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Clerk</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam R. Knachel</u>				14. MOTHER'S MAIDEN NAME <u>Lula Fitzell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-0851</u>		17. INFORMANT <u>Wife</u>		ADDRESS <u>2805 Evergreen Ave.</u>	
18. <u>433.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute suppurative bronchitis pneumonia</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>stroke</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cerebrovascular disease</u>		(C) <u>14 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>5-22-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Respiratory Obstruction</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> 19 <u>70</u> to <u>6/1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) <u>(di)</u> (did not) view the body after death.							
23A. SIGNATURE <u>William L. Bodde MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/8/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>William L. Bodde</u>				23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Rick Inc.</u>		ADDRESS <u>Balto. Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

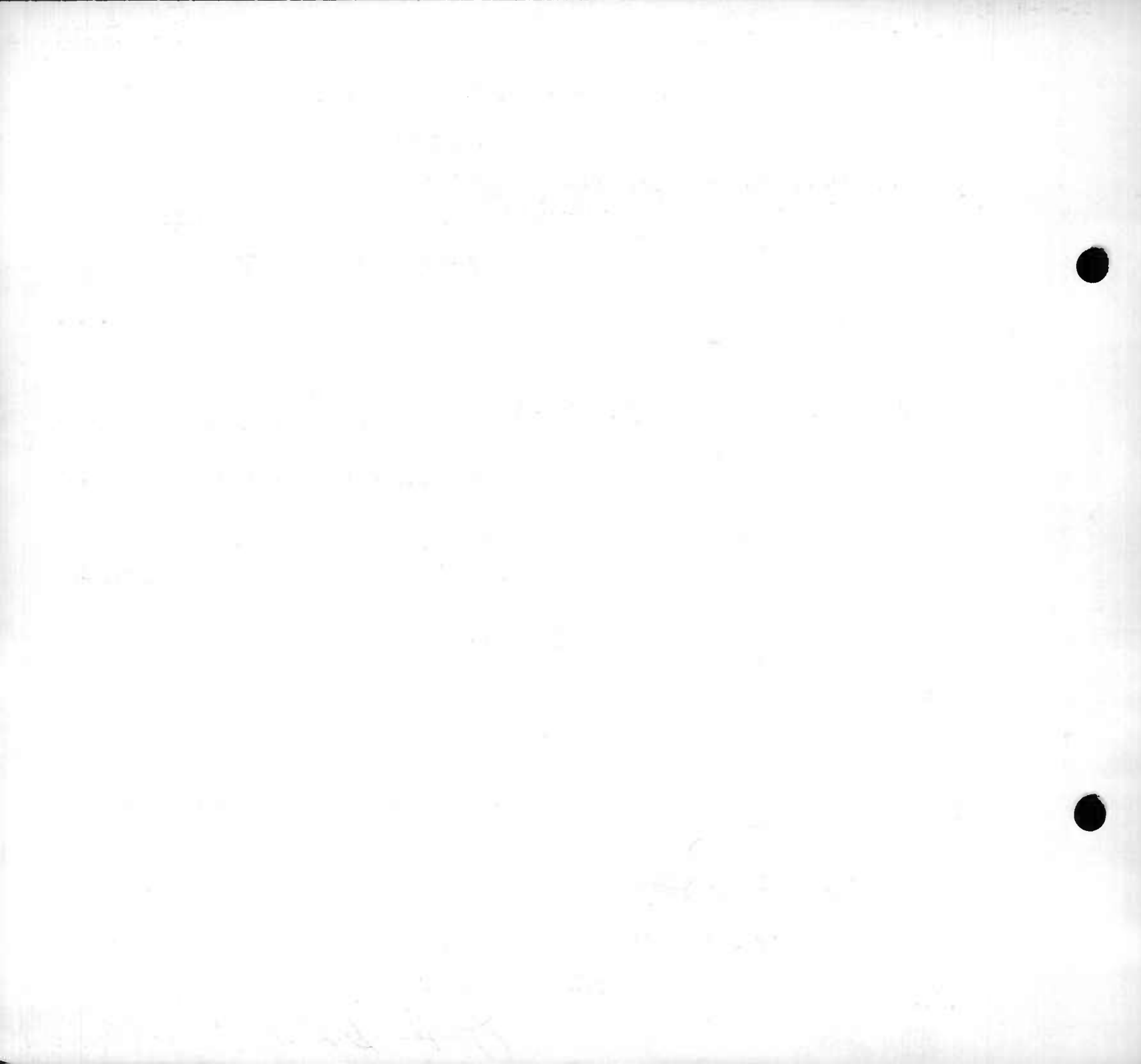
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5685</span>	
BIRTH NO. <span style="font-size: 1.5em;">M-450 70 5685</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Jake Mellon</u>			2. DATE AND HOUR OF DEATH <u>5-31-1970 12:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2403</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1213 Light St.</u>		
5. SEX <u>m</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1896</u>	9. AGE (in years last birthday) <u>73</u>	10. Under 1 Yr. Months: <u>  </u> Days: <u>  </u> Hours: <u>  </u> Min. <u>  </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Security-Police</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Christian Mellon</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Cook</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Donald Mellon Owensboro, Ky.</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD &amp; arrhythmia</u> <u>Phlebitis &amp; Cellulitis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>5-14-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rectal Abscess</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>5-12</u> 19 <u>70</u> to <u>5-31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5-31</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert J. Prosser</u>			23B. DATE SIGNED <u>6/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>  </u>
23D. ADDRESS <u>  </u>			23E. ADDRESS <u>  </u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/4/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem. Pk</u>	
24D. LOCATION <u>Glen Burnie, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		24F. NAME OF REGISTRAR <u>  </u>	
24G. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>		24H. ADDRESS <u>715 Light St.</u>			



## FUNERAL DIRECTOR: IMPORTANT

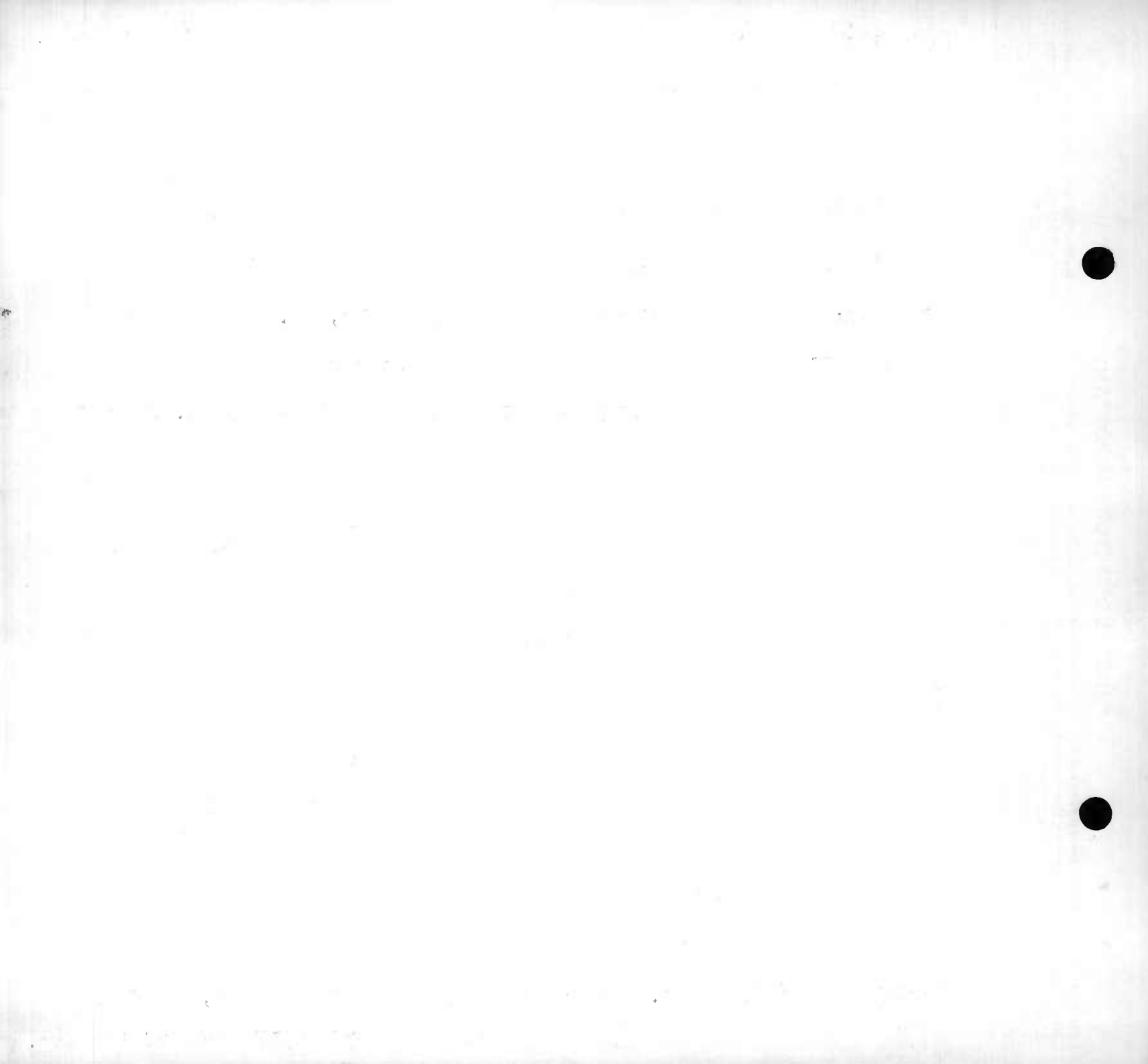
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 70 5686		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5686	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WESLEY Prescoe JOHNSON</b>		2. DATE AND HOUR OF DEATH <b>6/2/70 11:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2739</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-19</b> 9. AGE <b>51</b> (lost birthdate)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry</b>		14. MOTHER'S MAIDEN NAME <b>Laura Prescoe</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-0891</b>		17. INFORMANT <b>4940 Eastern Avenue</b> ADDRESS <b>BCH: Records Baltimore, Maryland 21224</b>	
18. <b>199.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HYPOGLYCEMIA &amp; HYPO KALEMIA.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>SARCOMA WITH MULTIPLE METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>2 YEARS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>SEVERE ANEMIA.</b>					
19A. DATE OF OPERATION <b>2-1-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>5/30/70</b> 19 to <b>6/2/70</b> 19 that (I) (we) last saw the deceased alive on <b>6/1/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Castro</b>		23B. DATE SIGNED <b>6-2-70</b>		23C. PHYSICIAN'S NAME (Type) <b>E. CASTRO MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-5-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Anteburn Mem. PR</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Joseph G. Locks</b>		ADDRESS <b>1304 N. Central Ave</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>R-326</b>      <b>70 5687</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70 5687</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>LOUISE RODGERS</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>6-3-70 14.35 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>22 SINAI HOSPITAL</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2788</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>22 SINAI HOSPITAL</b></p>		<p><b>C. CITY OR TOWN</b> <b>BALTIMORE</b></p>	<p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
		<p><b>E. STREET AND NUMBER</b> <b>5402 DENMORE AVE.</b></p>	
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. RACE</b> <b>negro</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>8-2-95</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Private</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>74</b></p>
		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Howardsville, Md.</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>
<p><b>13. FATHER'S NAME</b> <b>Frank Bell</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>	<p><b>16. SOCIAL SECURITY NO.</b> <b>213 36 5491A</b></p>	<p><b>17. INFORMANT</b> <b>Robert Rogers</b> <b>650 N. Carrollton Ave.</b></p>	
<p><b>18. CAUSE OF DEATH</b> <b>412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>DISEASE</b> (A) IMMEDIATE CAUSE <b>CEREBRO VASCULAR DUE TO, OR AS A CONSEQUENCE OF:</b> <b>LAZ DISEASE</b> (B) <b>ATROSCLECTOTIC CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF:</b> (C) _____ <b>PARKINSON'S DISEASE</b></p>			<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>DAYS</b> <b>YEARS</b> <b>YEARS</b></p>
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> 19 <u>70</u> to <u>6-3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>[Signature]</i> <b>MD</b> DEGREE</p>			<p><b>23B. DATE SIGNED</b> <b>6-3-70</b></p>
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>ROBEN DRIZANSKI MD</b> DEGREE</p>			<p><b>23D. ADDRESS</b> <b>SINAI HOSP.</b></p>
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>	<p><b>24B. DATE</b> <b>6/6/70</b></p>	<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <b>St. Thomas Cemetery</b></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Randallstown, Maryland</b></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUN 11 1970</b></p>	<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b></p>	<p><b>25C. FUNERAL DIRECTOR</b> <b>LEWIS T. GWYNN</b> <b>4517 Park Heights Ave.</b></p>	





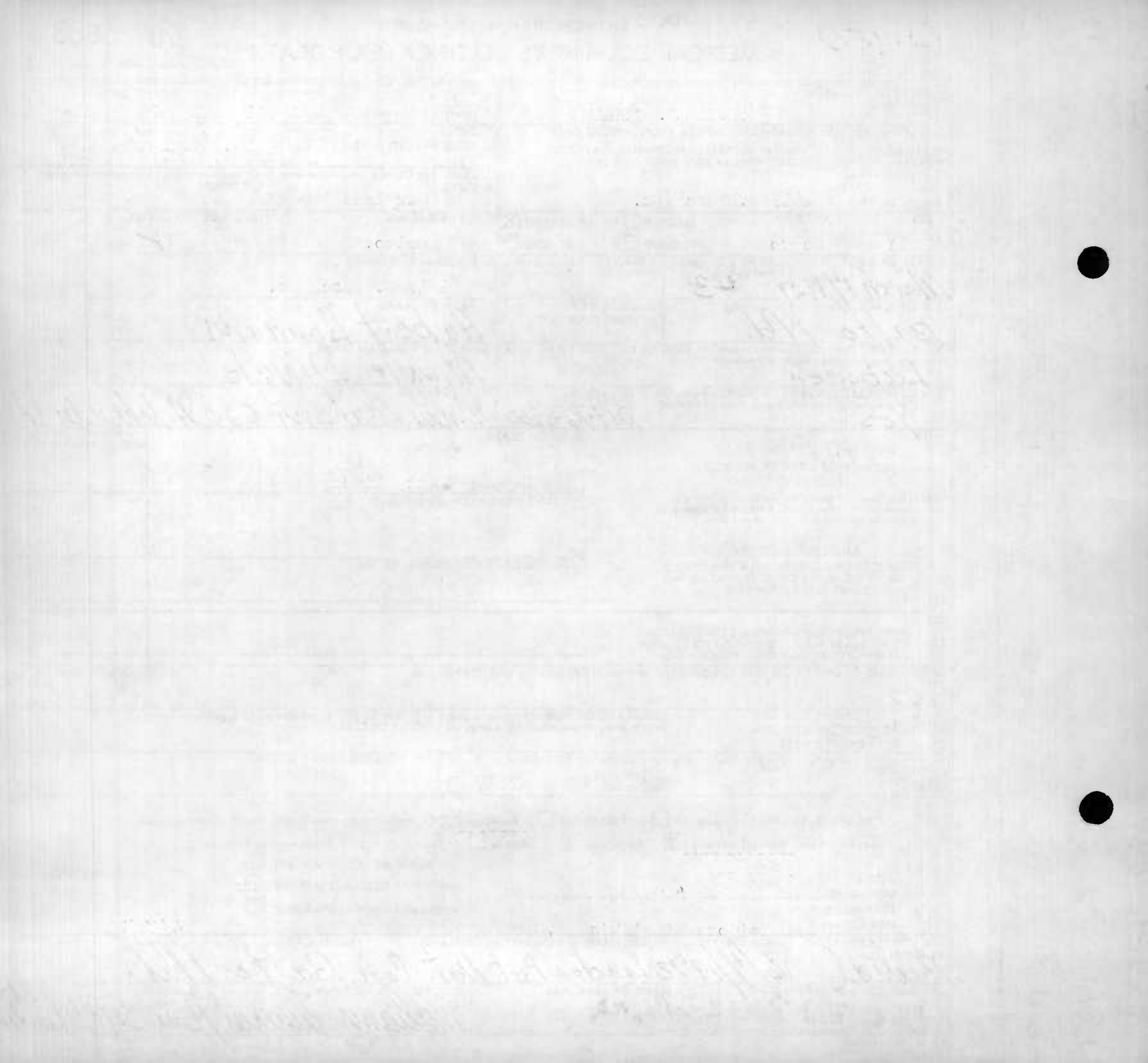
G-650

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

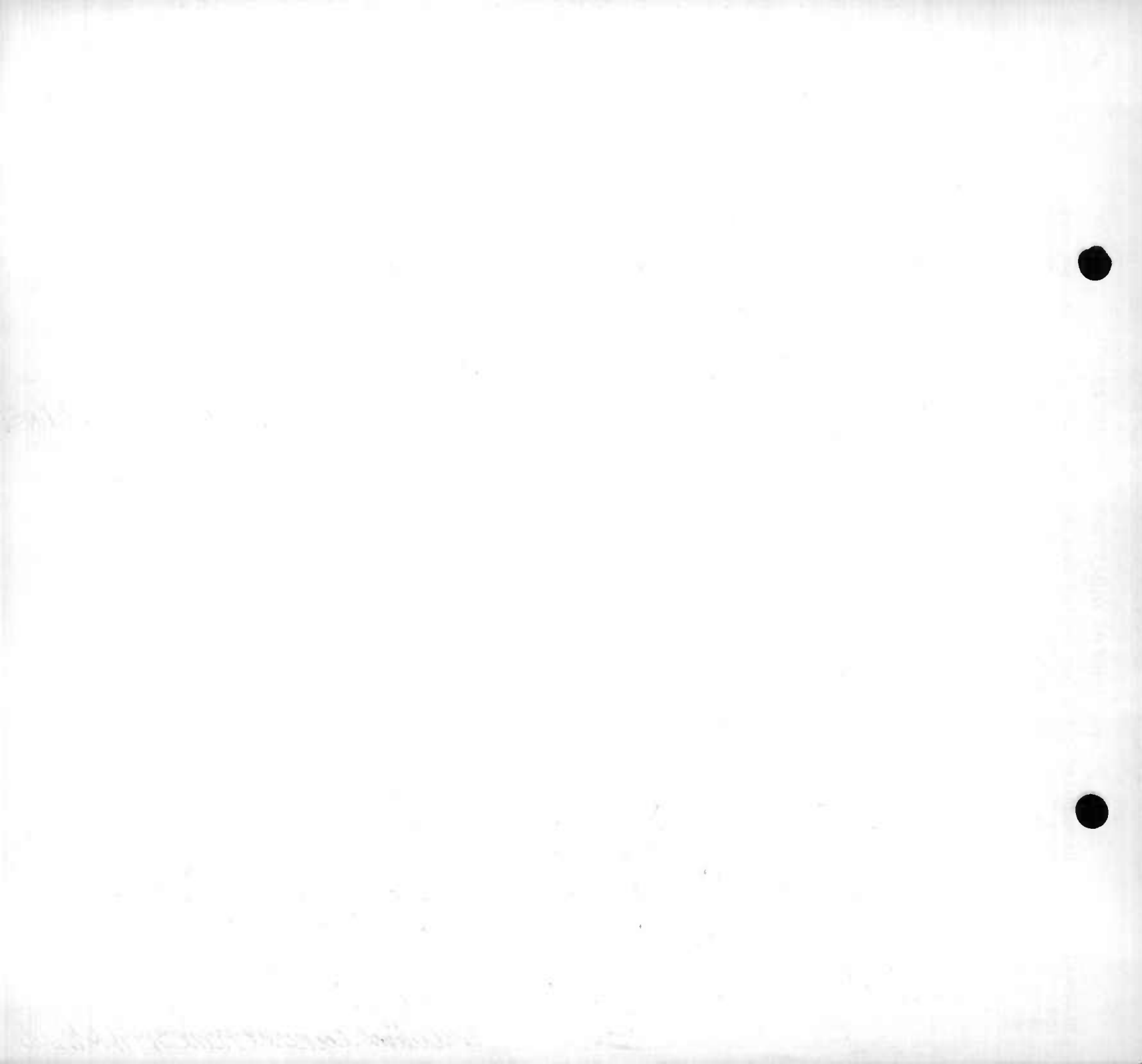
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY J. GRAHAM</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 11 70</b> 8 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1019 S. Peach St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 11, 1970</b> 8 p. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>March 14, 1927</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hubert Graham</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Minnie Dingle</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>214-6-8200</b>		18. INFORMANT <b>Anna Graham</b>	
19. CAUSE OF DEATH <b>571.8 I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty liver</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>4/12/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/4/1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Louder Park Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fabel</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Schreder St.</b>	



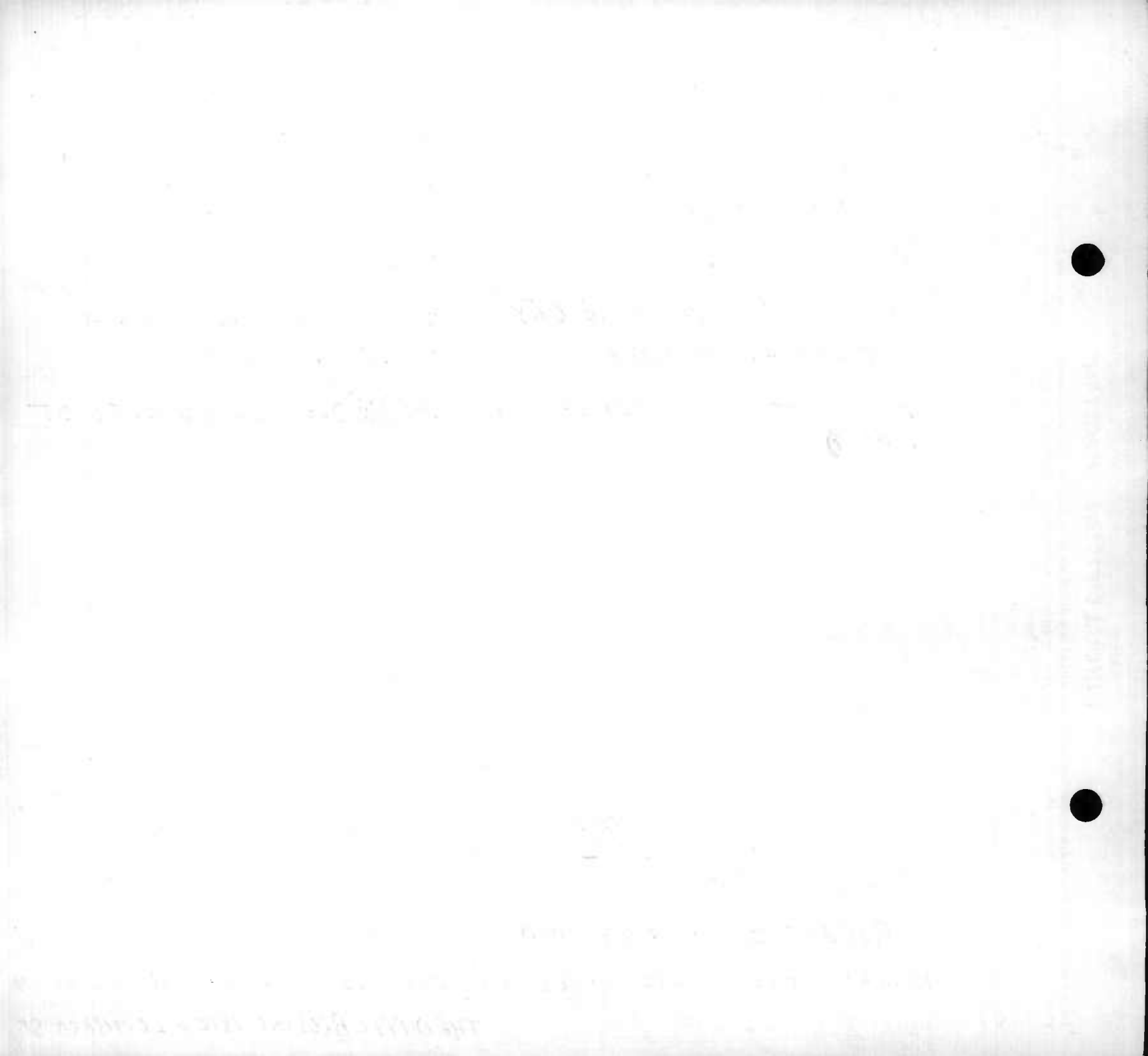
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5689</u>	
W-452 70 5689		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Williams, Louellen</u>		2. DATE AND HOUR OF DEATH <u>6-3-70</u> <u>7:00</u> <u>a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bow Secours Hospital</u> <u>2055 W Fayette St</u> <u>Balto Md 21223</u>		A. STATE <u>Md.</u> B. COUNTY <u>1603</u>	
C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1624 W-FRANKLIN ST</u> <u>21223</u>			
5. SEX <u>F</u>	6. RACE <u>NO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-90</u>
9. AGE (in years last birthday) <u>80</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia, Essex</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Emma J. West</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Glover &amp; Butler</u>		ADDRESS <u>1624 W-FRANKLIN ST</u>	
18. <u>560.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Small intestinal obstruction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Abdominal adhesions</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Generalized arteriosclerosis</u> <u>years</u>	
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <u>5-21</u> 19 <u>70</u> to <u>6-2</u> 19 <u>70</u> that (I) <del>(we)</del> last saw the deceased alive on <u>6-2</u> 19 <u>70</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.			
23A. SIGNATURE <u>Tain C. Kerr M.D. Ch.B.</u>		23B. DATE SIGNED <u>6-3-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Tain C. Kerr M.D. Ch.B.</u>		23D. ADDRESS <u>Bow Secours Hosp.</u> <u>2055 W. Fayette St</u> <u># 23</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Walter Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>5197 N. Broadway</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5690	
BIRTH NO. 70 5690				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Richard Paul Bridge</b>			2. DATE AND HOUR OF DEATH <b>6/3/70 4:40 P</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>201</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b> <b>34 Calvert &amp; Sara Hoga Sts</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>MAY 27 1932</b>		9. AGE (In years last birthday) <b>38</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sanitation Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>CHARLES BRIDGE</b>		
14. MOTHER'S MAIDEN NAME <b>LOUISE BIEBLE</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>219-28-8034</b>			17. INFORMANT <b>CHARLES BRIDGE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of larynx &amp; metastases to neck and chest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6/1/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>70</b> to <b>6/3</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/3</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert Z. Berry M.D.</b>				23B. DATE SIGNED <b>6/3/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT Z. BERRY MD</b>				23D. ADDRESS <b>211 Medical Arts Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JUNE 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 BELAIR RD BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>			
25B. NAME OF REGISTRAR <b>Robert Z. Berry</b>		25C. FUNERAL DIRECTOR <b>THE DIPPAC BROS INC</b>			
25D. ADDRESS <b>1800 E LOMBARD ST</b>					



1

K-420 70 5691 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 5691

1. NAME OF DECEASED (Type or Print) <b>JOSEPH L. KOWALIK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 2 70 6:50 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 529 S. Chapel St. D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 2, 1970 6:50 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10/12/17</b>		10. AGE (in years) If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ignacy Kowalik</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	
15. MOTHER'S MAIDEN NAME <b>Catherine Surowska</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>217-07-0499</b>		18. INFORMANT ADDRESS <b>Mr. Ignatius D. Kowalik, 529 S. Chapel St.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.0 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>6/3/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/6/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970 Robert E. Taylor, M.D.</b>		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">70 5692</span>				
BIRTH NO. <span style="font-size: 1.2em;">333051</span> 5692					M.E. CASE NO. <span style="font-size: 1.2em;">333051</span>				
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Stevens, Adam A.</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 3 '70 8:45 A.M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">48 Maryland General Hospital</span>					A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">5300</span>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>				
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">7009 Beech Ave.</span>				
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/5/99</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Crane operator</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Beth. Steel Corp.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Stevens, William</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Antoinette ?</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes WW 2 12-09-3906</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-09-3906</span>		17. INFORMANT <span style="font-size: 1.2em;">Frank J. Sokoloski</span>				
					ADDRESS <span style="font-size: 1.2em;">609 Old Home Rd. 21206</span>				
18. <span style="font-size: 1.2em;">412.4 I</span> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Atherosclerotic cardiovascular disease</span>					(A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <span style="font-size: 1.2em;">5-10-70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Gangrene of foot</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">May 9</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">June 3</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">June 3</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">Francis A. Clark, Jr. M.D.</span> <span style="font-size: 1.2em;">Shao-Huang Chiu</span>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">June 3 '70</span>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <span style="font-size: 1.2em;">11 E. Chase St Baltimore 21202</span>				
24A. BURIAL CREMATION REMOVAL (Specify) <span style="font-size: 1.2em;">burial</span>		24B. DATE <span style="font-size: 1.2em;">6 June 70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">St. Stanislaus Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 4 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. E. Taber, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Dippel Bros Inc. 8110 Belair Rd. 21206</span>					

8-2-18

70

70-70

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10 June

10 June

10 June

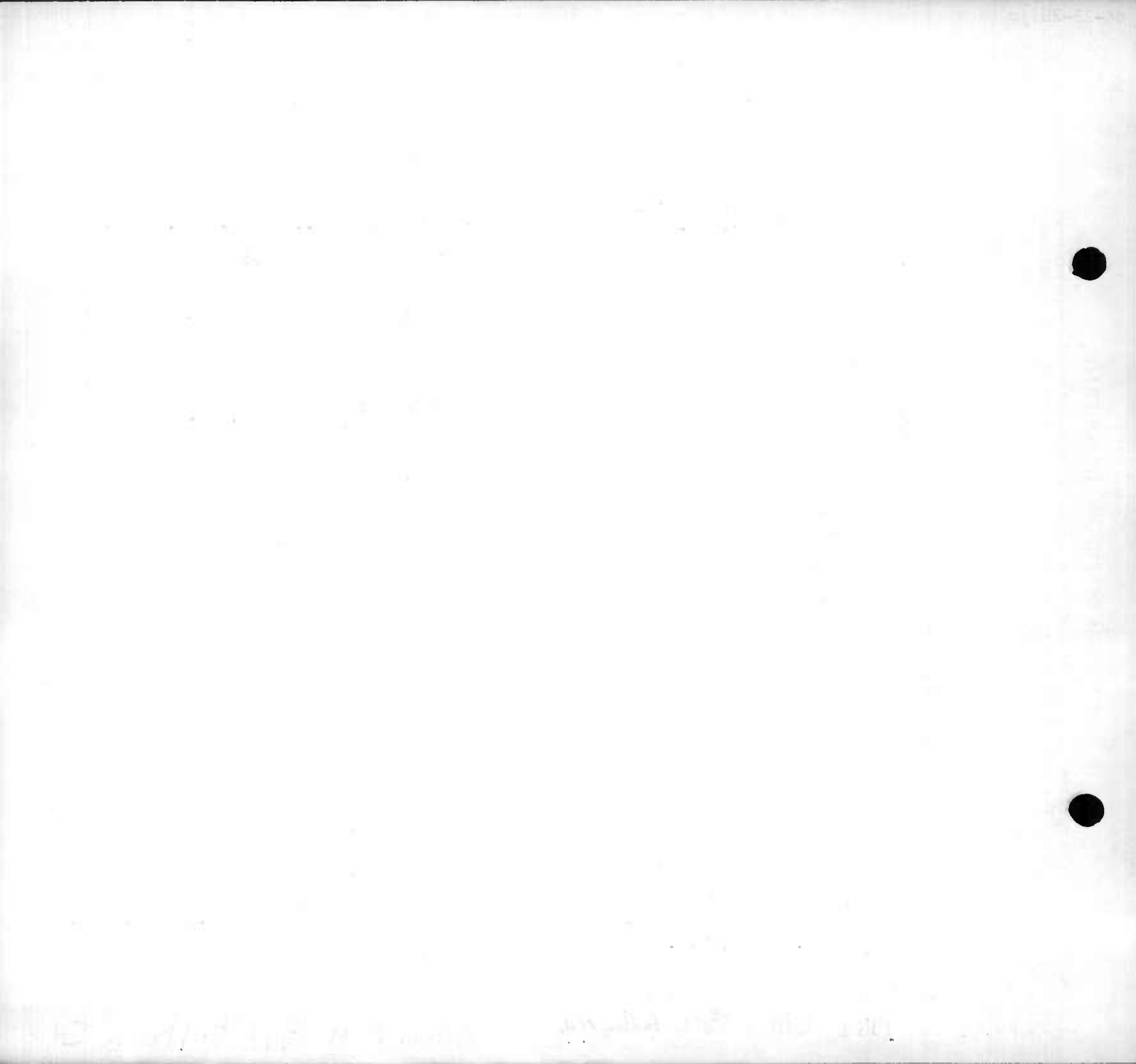
Blue-throated

10 June

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

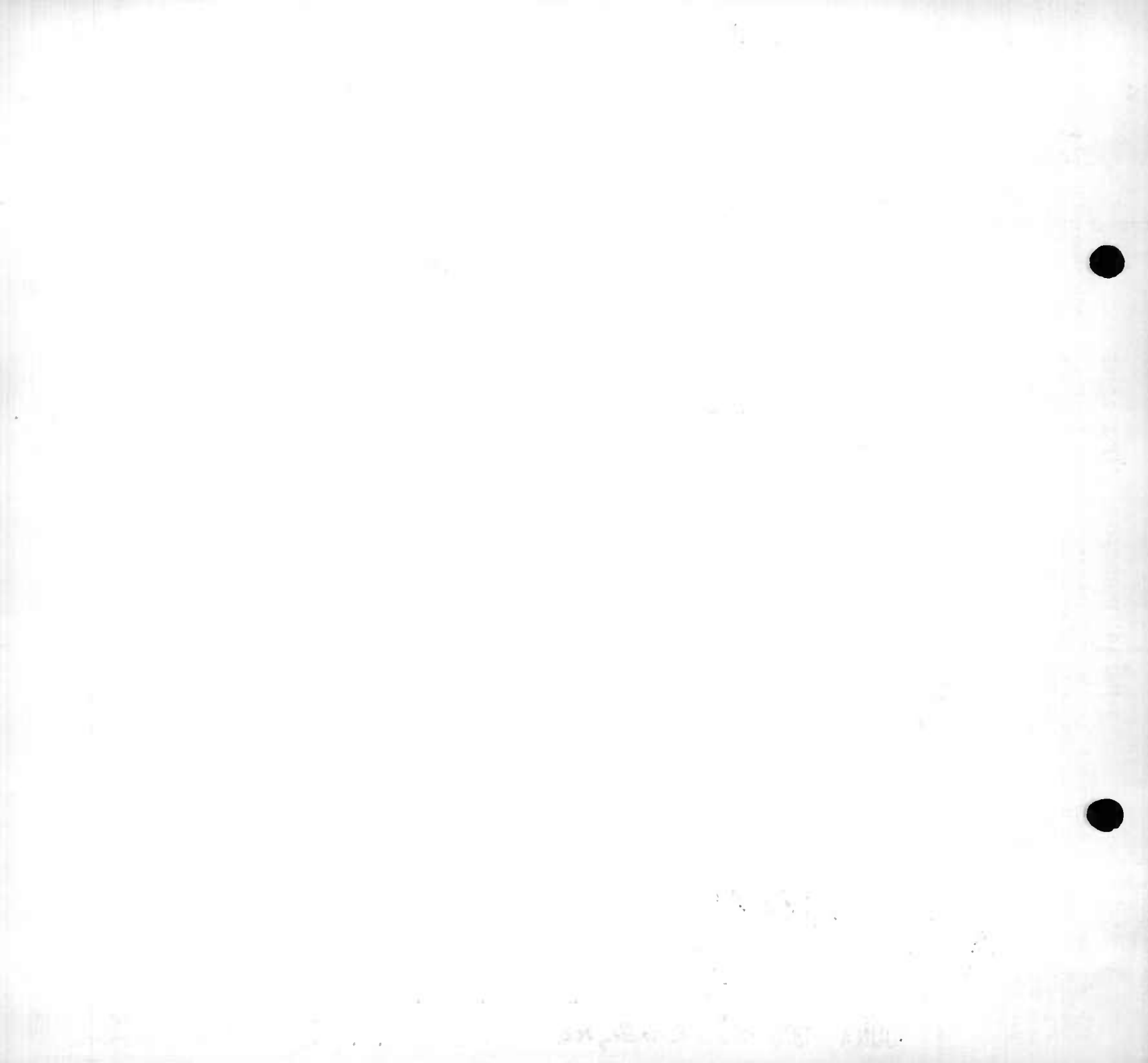
BIRTH NO. 70 5694				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5694			
1. NAME OF DECEASED (Type or Print) <u>Elsie Seymour</u>				2. DATE AND HOUR OF DEATH <u>5/30/70 10:45 P.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1501</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1342 Whatcoat St., Balto., Md. 21217</u>											
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-16</u>		9. AGE (in years, last birthday) <u>53</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				13. FATHER'S NAME <u>Abraham Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Carrie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT BCH Records: <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>			
18. <u>199.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>metastatic Ca</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>bacterial endocarditis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION				19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>YES</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/30/70</u> to <u>5/30/70</u> and that (I) (we) last saw the deceased alive on <u>5/30/70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Lynne I. Neefe</u>				23B. DATE SIGNED <u>5/30/70</u>							
23C. PHYSICIAN'S NAME (Type) <u>Lynne I. Neefe, M.D.</u>				23D. ADDRESS <u>4940 Eastern Ave., Balto., Md. 21224</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>6-4-70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>			
24D. LOCATION <u>Balto. 68d.</u>											
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>Nelson F. A. 1348 Calhoun St.</u>			
25D. ADDRESS <u>1348 Calhoun St.</u>											



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

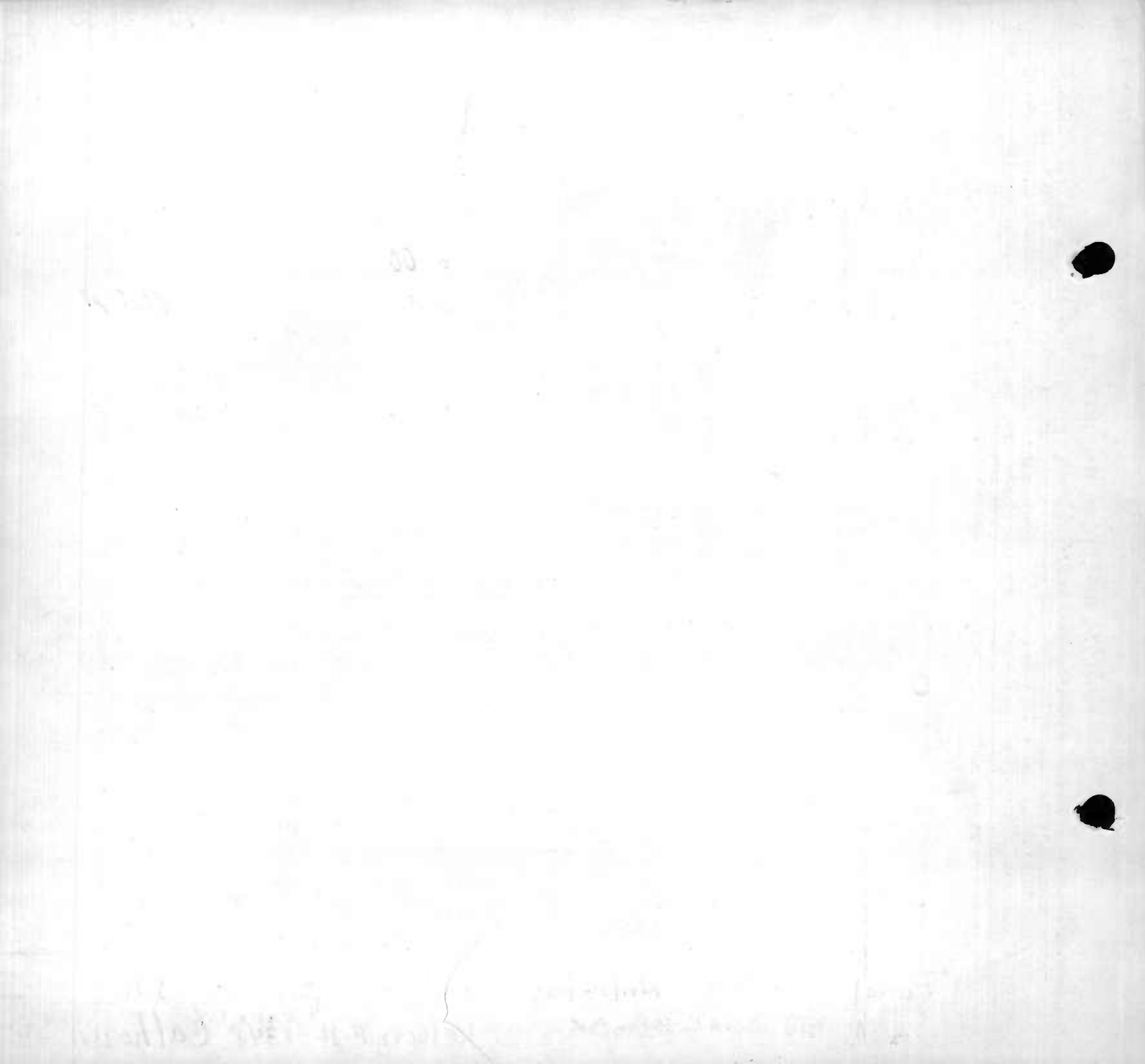
70 5693		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5693	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Cornelius Butler		6-2-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		1303	
2308 Madison Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2308 Madison Avenue			
5. SEX Male	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-94	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Chauffeur		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Butler		14. MOTHER'S MAIDEN NAME Harriett Evans		12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 7-1-18*12-9-18		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Missouri Conway 1811 Gwynns Falls.Pk.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 + 25-0.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Denial	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to June 2 1970 that (I) (we) last saw the deceased alive on June 2 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph B Gross		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Joseph B Gross		23D. ADDRESS 6911 Park Heights W. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-70		24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l. Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 5695
BIRTH NO.		70 5695		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CUNNINGHAM, HANOV</u>			2. DATE AND HOUR OF DEATH <u>5-31-70</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u>			A. STATE <u>MD.</u> B. COUNTY <u>BA</u>		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2707 Rosy Ln Ave</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-00</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B+O</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Bolton Hill Nursing Home 1400 John St.</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Urinary tract infection, Decubitus Ulcers</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CVA with left hemiparesis &amp; confusion</u>  <u>AK amputation @ leg</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>3 months</u> <u>Jan. 6, 1970</u> <u>Unknown</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>March 27</u> 19 <u>70</u> to <u>May 31</u> 19 <u>70</u> , that (H) (we) last saw the deceased alive on <u>May 31</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u>			23B. DATE SIGNED <u>May 31, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u>
23D. ADDRESS <u>1111 Park Avenue Baltimore, Maryland 21201</u>			23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-3-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk. Balto. Md.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>			
24F. NAME OF REGISTRAR <u>Robert E. Haber, M.D.</u>		24G. FUNERAL DIRECTOR <u>Kelson F.H.</u>		24H. ADDRESS <u>1348 Calhoun St.</u>	





FUNERAL DIRECTOR: IMPORTANT

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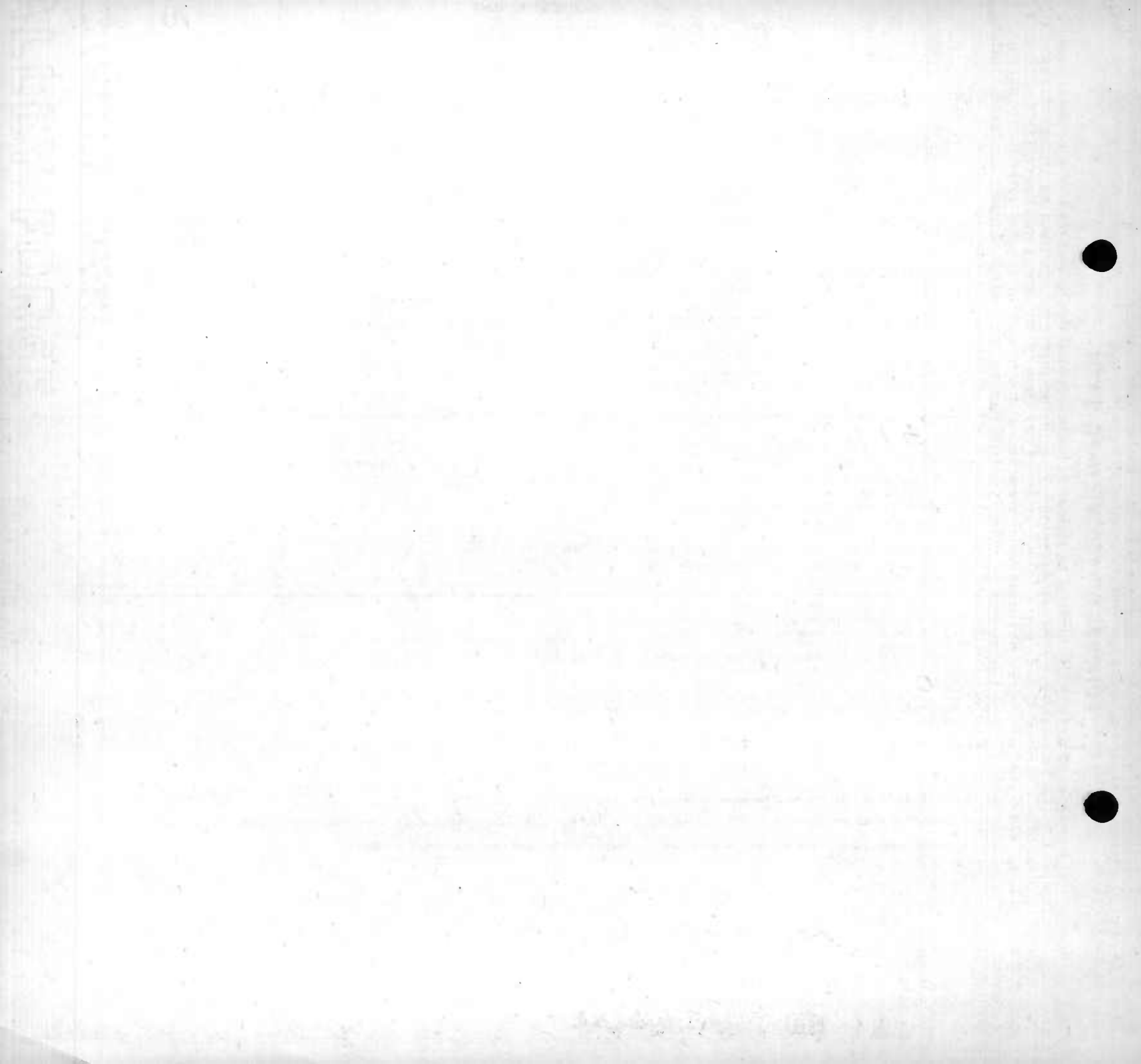
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5696</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5696</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Romie Lyles</b>			2. DATE AND HOUR OF DEATH <b>5/30/70</b> <span style="float: right;"><b>7.00 A</b> M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>3778 Columbus Dr.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <span style="float: right;"><b>1511</b></span>		
5. SEX <b>M</b>		6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/1900</b>	9. AGE (In years lost birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Lyles</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Taylor</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/18/1918</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Irene Lyles 3778 Columbus Dr</b>		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>Generalized Cancer</b> <b>Gastric Ca.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>unknown</b> <b>several years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca. Stomach</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>May 30</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>May 28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles Tommasello M.D.</b>			23B. DATE SIGNED <b>June 1/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Charles Tommasello M.D.</b>
23D. ADDRESS <b>900 W. Lombard &amp; Balt. Ave.</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>6/3/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice 661 W. Barre St</b>	



# FUNERAL DIRECTOR: IMPORTANT

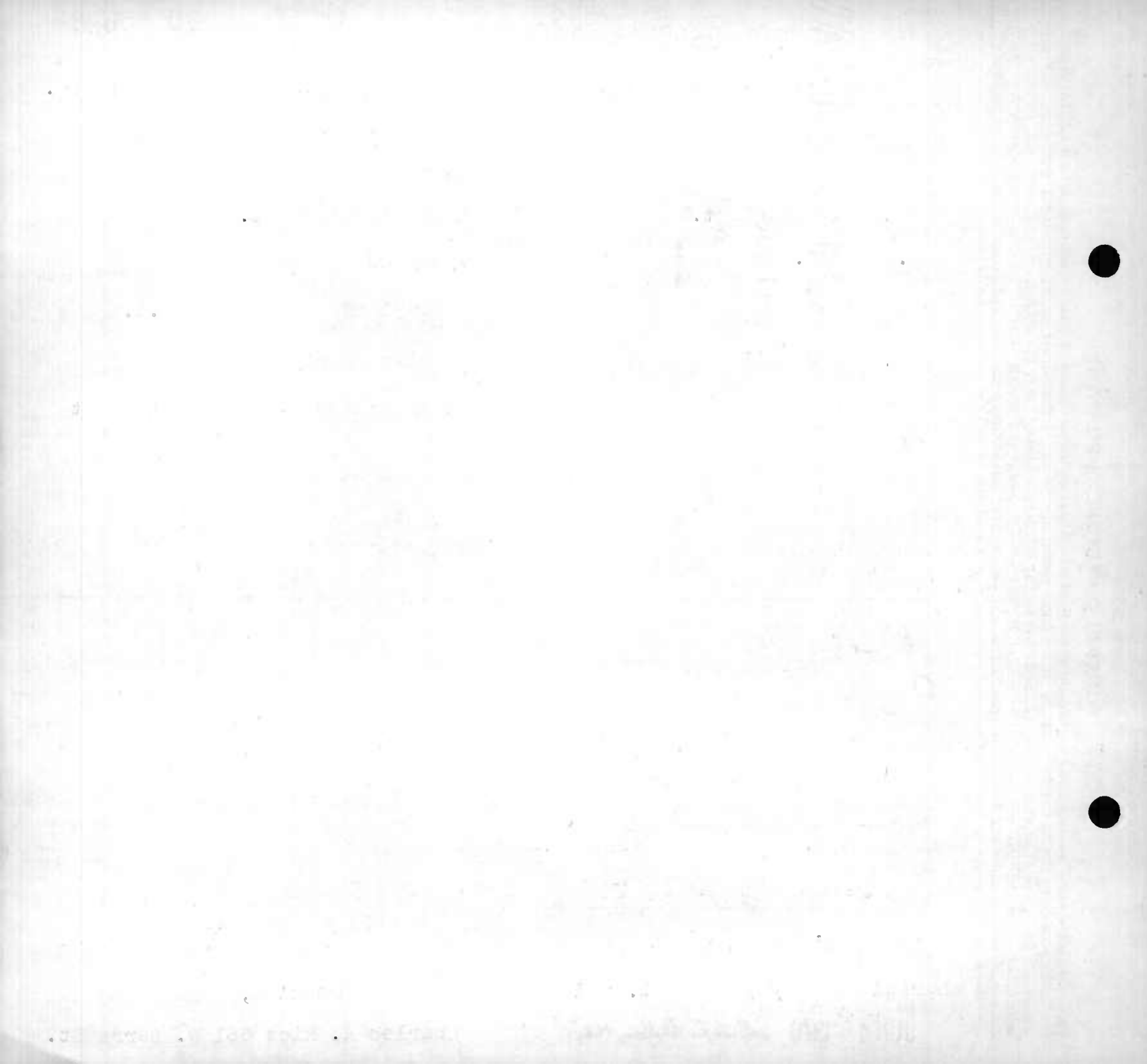
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5697</span>	
70 5697				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James A Butler</i>		2. DATE AND HOUR OF DEATH <i>May 26, 1970 4:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1703</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Melchor Nursing Home</i> <i>90 2327 McCharles St.</i>			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>125 George St Apt 10 B.</i>		
5. SEX <i>M</i>	6. RACE <i>N.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26/98</i>		9. AGE (In years last birthday) <i>72</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Trucking</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>James A Butler</i>			14. MOTHER'S MAIDEN NAME <i>Mrs. Harriet Barnes</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>U</i>		16. SOCIAL SECURITY NO. <i>218-055076</i>		17. INFORMANT <i>Friend</i> <i>Mrs. Irene Christolm</i>	
18. <i>5192</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cor Pulmonale</i> (B) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i> <i>Many years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>May 13</i> 19 <i>70</i> to <i>May 20</i> 19 <i>70</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>May 25</i> 19 <i>70</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Koy M. Zimmerman MD</i> DEGREE				23B. DATE SIGNED <i>5/28/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Koy M. Zimmerman M.D.</i> DEGREE				23D. ADDRESS <i>3202 Harford Rd, Baltimore, MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/29/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 4 1970</i>		25B. NAME OF REGISTRAR <i>Viobert E. Taylor R.D.</i>		25C. FUNERAL DIRECTOR <i>Charles D. Rice</i>	
				ADDRESS <i>661 W. Borne St.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5698</span>	
70 5698				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bernice Spriggs Holmes Ackwood		5/30/70 7:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  00 1354 Cleveland St.				A. STATE Maryland	
				B. COUNTY	
2. DATE AND HOUR OF DEATH				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1354 Cleveland St.					
5. SEX F.	6. RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/30	9. AGE (In years last birthday) 39
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Walter Marshall				14. MOTHER'S MAIDEN NAME Alice Spriggs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Ackwood 1354 Cleveland St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  Acute Coronary Occlusion Sudden Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5-1969 to 5-30-1970, that (I) last saw the deceased alive on 5-28-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts				23B. DATE SIGNED 6-1-71	
23C. PHYSICIAN'S NAME (Type) William H. Watts				23D. ADDRESS 555 N. Arlington St. Baltimore, Md 21203	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION Brooklyn, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 4 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Charles A. Rice		24H. ADDRESS 661 W. Barre St.			



70 5699

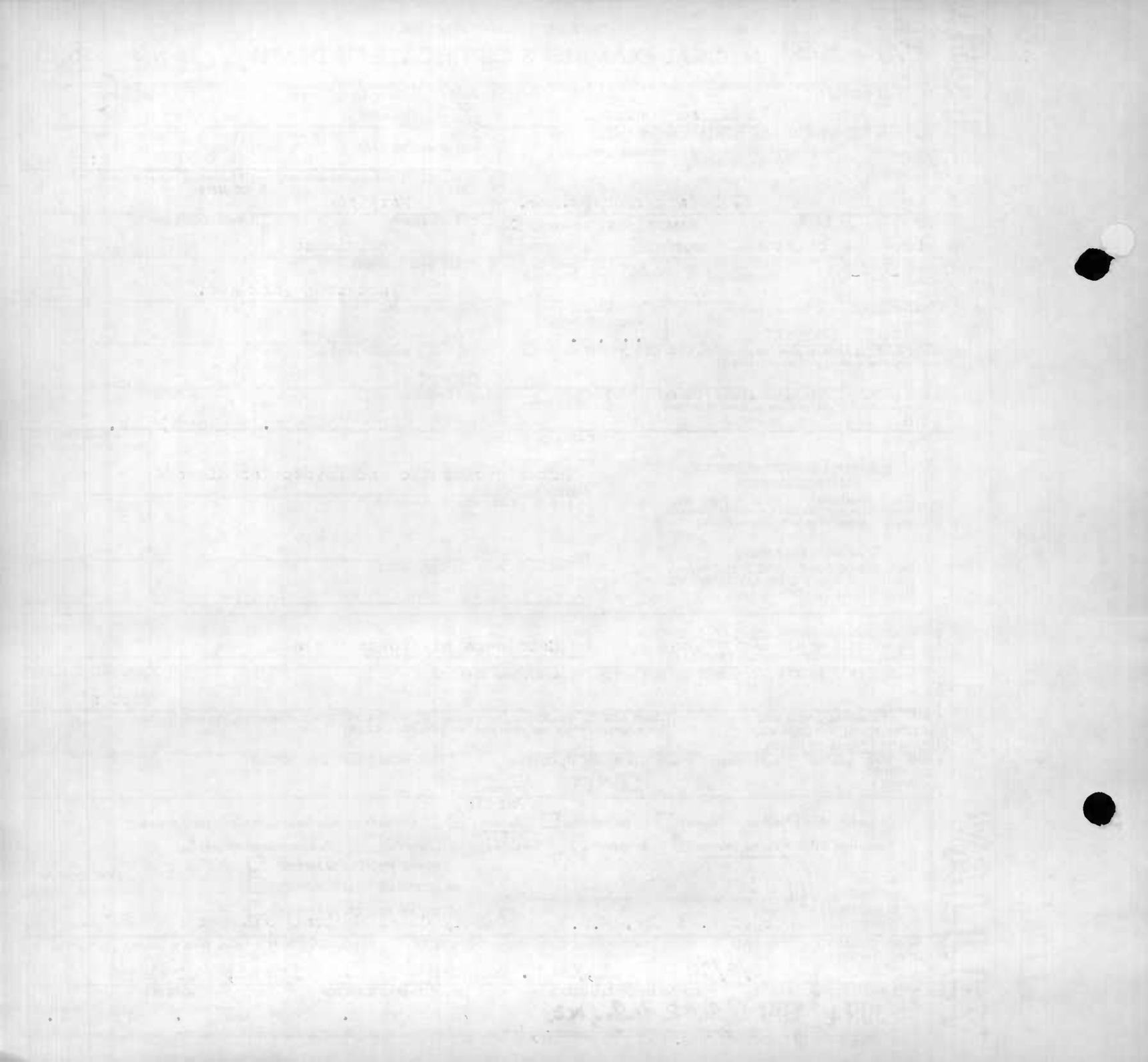
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5699

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Garrett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1733 Patterson Pk.Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 1 70 6:50 p.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802	
9. DATE OF BIRTH 12-25-03		10. AGE (in years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Garrie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Josie Farr		ADDRESS 2308 E. Federal St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Carcinoma of prostate gland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Partial	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. DATE SIGNED: 6/2/70 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	







B-623

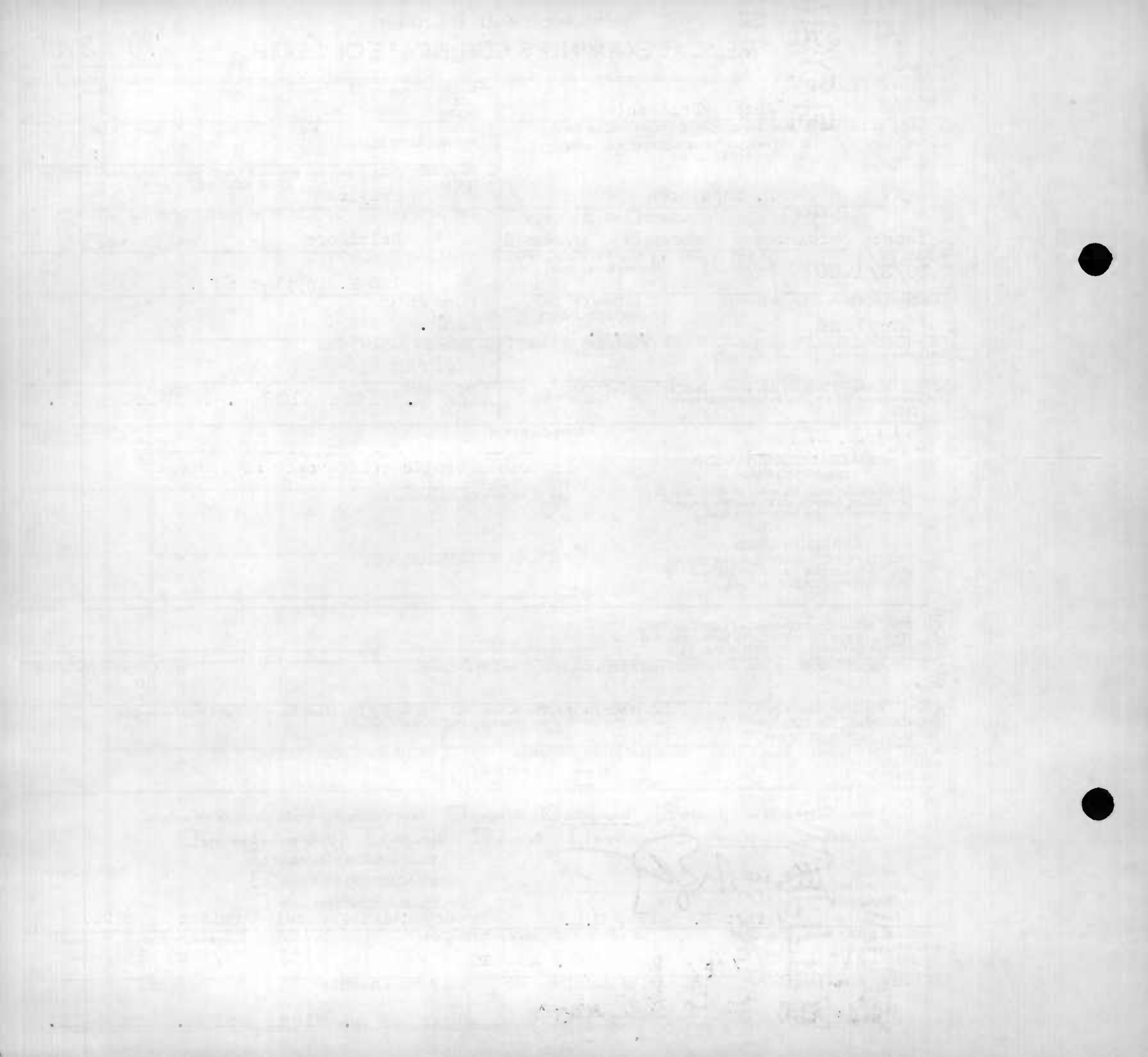
70 5700

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5700

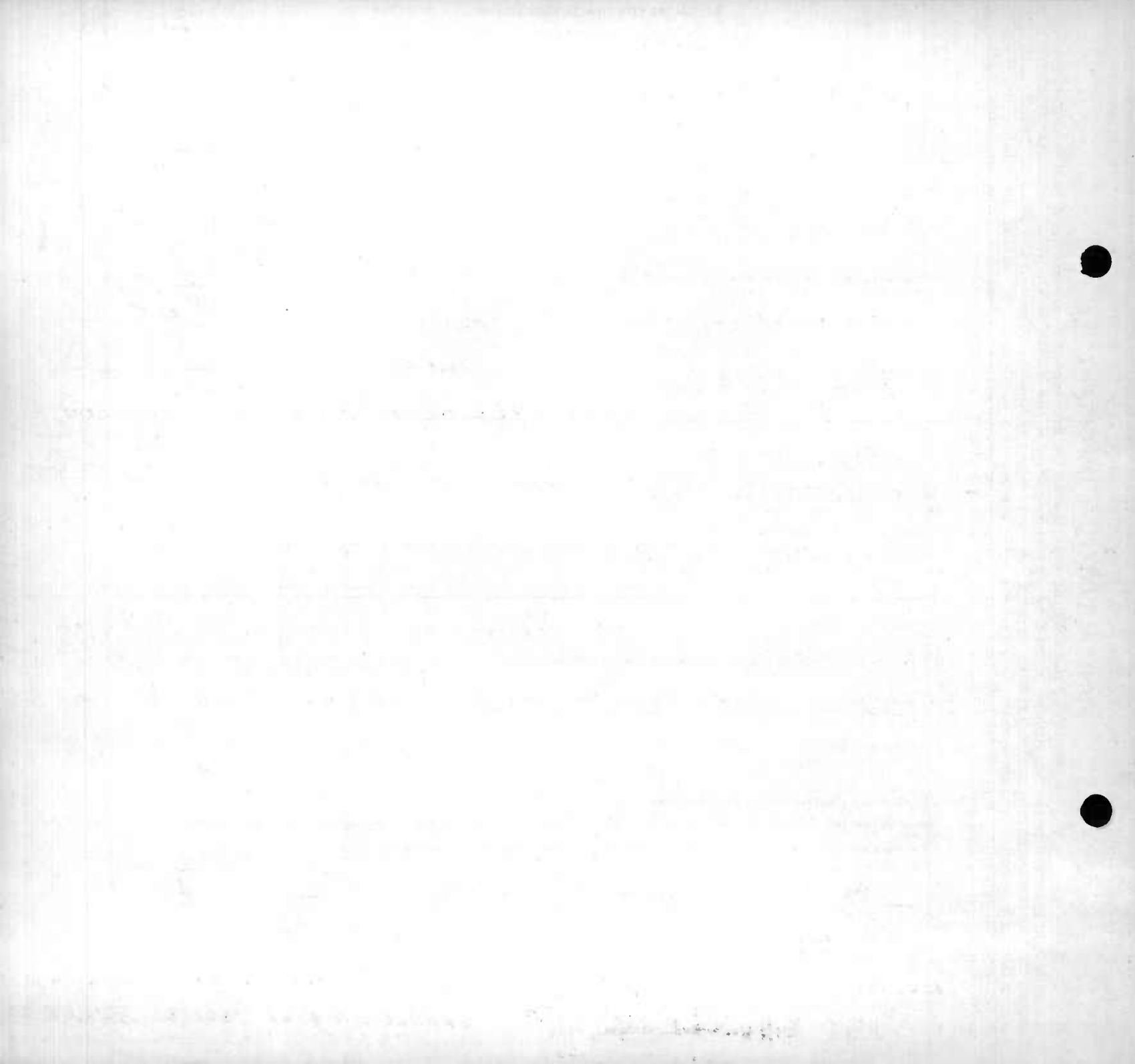
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
		Sarah Barksdale		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour		6 1 70 6:00 p. m.	
108 N. Poppleton		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		Maryland 1801	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS?
female	colored		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH	10. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)	E. STREET AND NUMBER		
10/3/1900	69	Maryland	108 N. Poppleton St.		
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
U.S.A.		unk.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
		Sarah		no	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
		Anna M. Pitts 108 N. Poppleton St.			
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
0				NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 6/2/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/5/70		MT. Auburn	
24D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 4 1970		E. J. Taylor, M.D.		Charles A. Rice 661 W. Barre St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 5701				70 5701	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Reaver P. Stevenson		May 29, 1970 4:03 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Melchor Nursing Home 90			A. STATE Maryland		B. COUNTY 2101
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 709 Dover St.					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1900	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-18-9648		17. INFORMANT Lincoln Powell 3000 Homewood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I Anterioralentic Cardio-vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Neurogenic Bladder			1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on May 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED May 29, 70	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.				23D. ADDRESS 3202 Hanford Rd, Baltimore, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/4/70		24C. NAME OF CEMETERY or CREMATORY MT. AUBURN	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970			
25B. NAME OF REGISTRAR E. Barber, MD.		25C. FUNERAL DIRECTOR CHARLES A. RICE 661 W. BARRE ST.			



70 5702

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 5702

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CALIMER, LENA MAY</b>		2. DATE AND HOUR OF DEATH <b>6-3-70 4:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Balt. City Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>203</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 6940, Eastern Ave, Balt. MD 21224</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		8. DATE OF BIRTH <b>2-12-26</b>	
13. FATHER'S NAME <b>Adam</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>		9. AGE (in years last birthday) <b>44 yr</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-3805</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
17. INFORMANT <b>BCH-Records Baltimore, Maryland 21224</b>		ADDRESS <b>4940 Eastern Avenue</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. I <b>1621</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Cerebral metastasis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>six months</b>	
		(B) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>10 months</b>	
		(C) <b>Hepatic metastasis</b>		<b>six months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-26-70</b> to <b>6-3-70</b> and that (I) (we) last saw the deceased alive on <b>6-3-70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Allen Kateran, M.D.</b>		23B. DATE SIGNED <b>6-3-70</b>		23C. PHYSICIAN'S NAME (Type) <b>R. VENKATESAN, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/5/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Corrothman Bapt. Ch. Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>James E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>4712 263 S. Conley St.</b>	

FUNERAL DIRECTOR: IMPORTANT

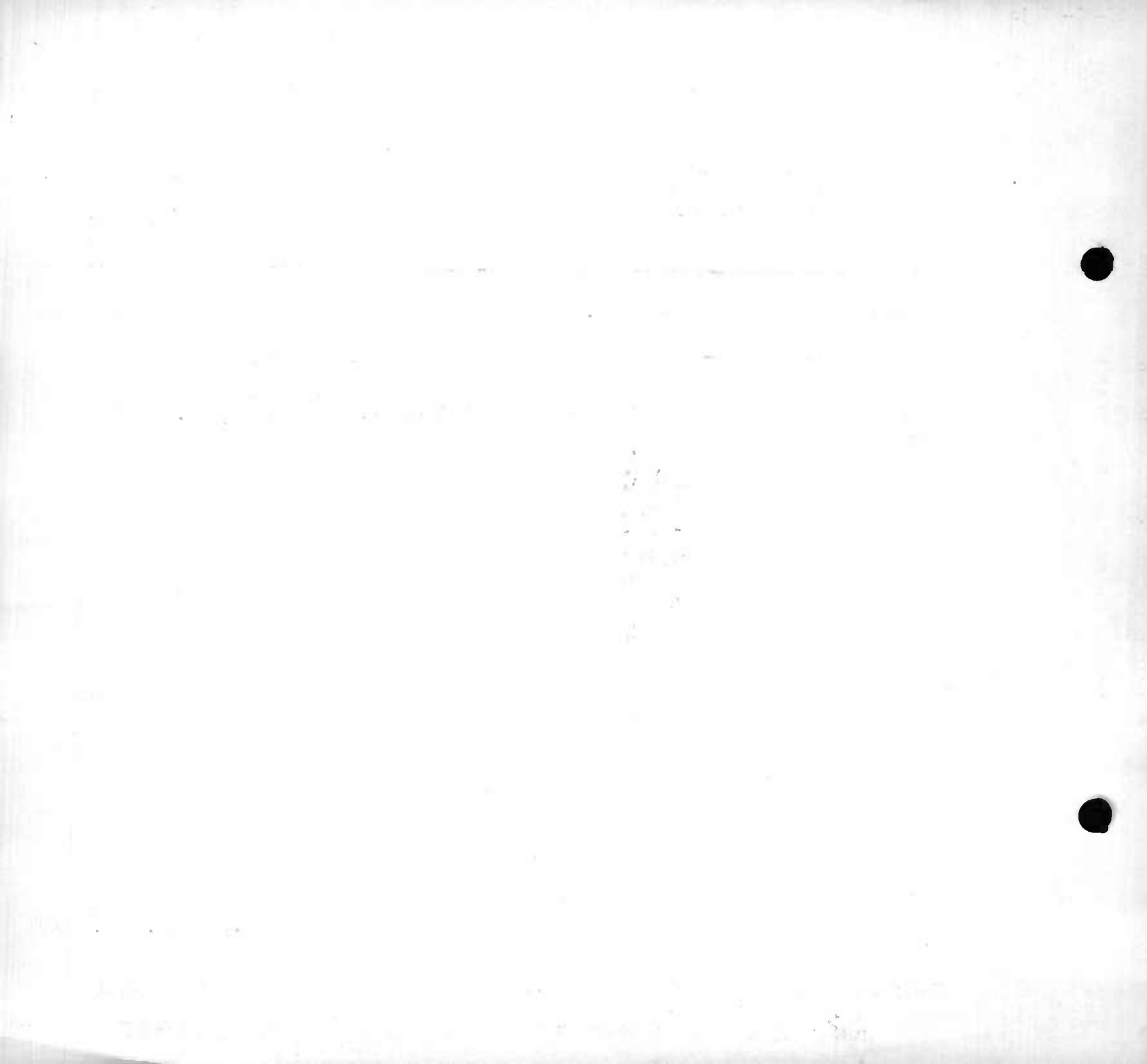
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 5703		70 5703		70 5703	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Howard Almony		6-1-70 7 05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224		A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5716 Rusk Ave. 3000 Park Ave., Balto., Md. 21215			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1882	9. AGE (In years last birthday) 88	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Salvage Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Joseph Almony-dec'd		14. MOTHER'S MAIDEN NAME Mary Ellen Horn-dec'd	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-03-0016		17. INFORMANT BCH Records: 4940 Eastern Avenue Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 884 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 5-11-70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED hip 20A. AUTOPSY? (Yes or No) Yes. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Haven Nursing Home 3939 Penhurst Ave. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 5-9-70 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? Fell from bed 22. I certify that (I) (this hospital) attended the deceased from 5-7-70 19 to 6-1 19 70 that (I) (we) last saw the deceased alive on 6-1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Kenneth C. Gertsen MD 23B. DATE SIGNED 6-1-70 23C. PHYSICIAN'S NAME (Type) KENNETH C. GERTSEN 23D. ADDRESS 4940 Eastern Ave., Balto., Md. 21224 BALTO. City Hosp. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 6-5-70 24C. NAME OF CEMETERY OR CREMATOR GOWAN PRESBYTERIAN CEM. 24D. LOCATION (City, town, or county) (State) BALTIMORE MD 25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Frank H. Seitz 25D. ADDRESS 814 W 36th St					

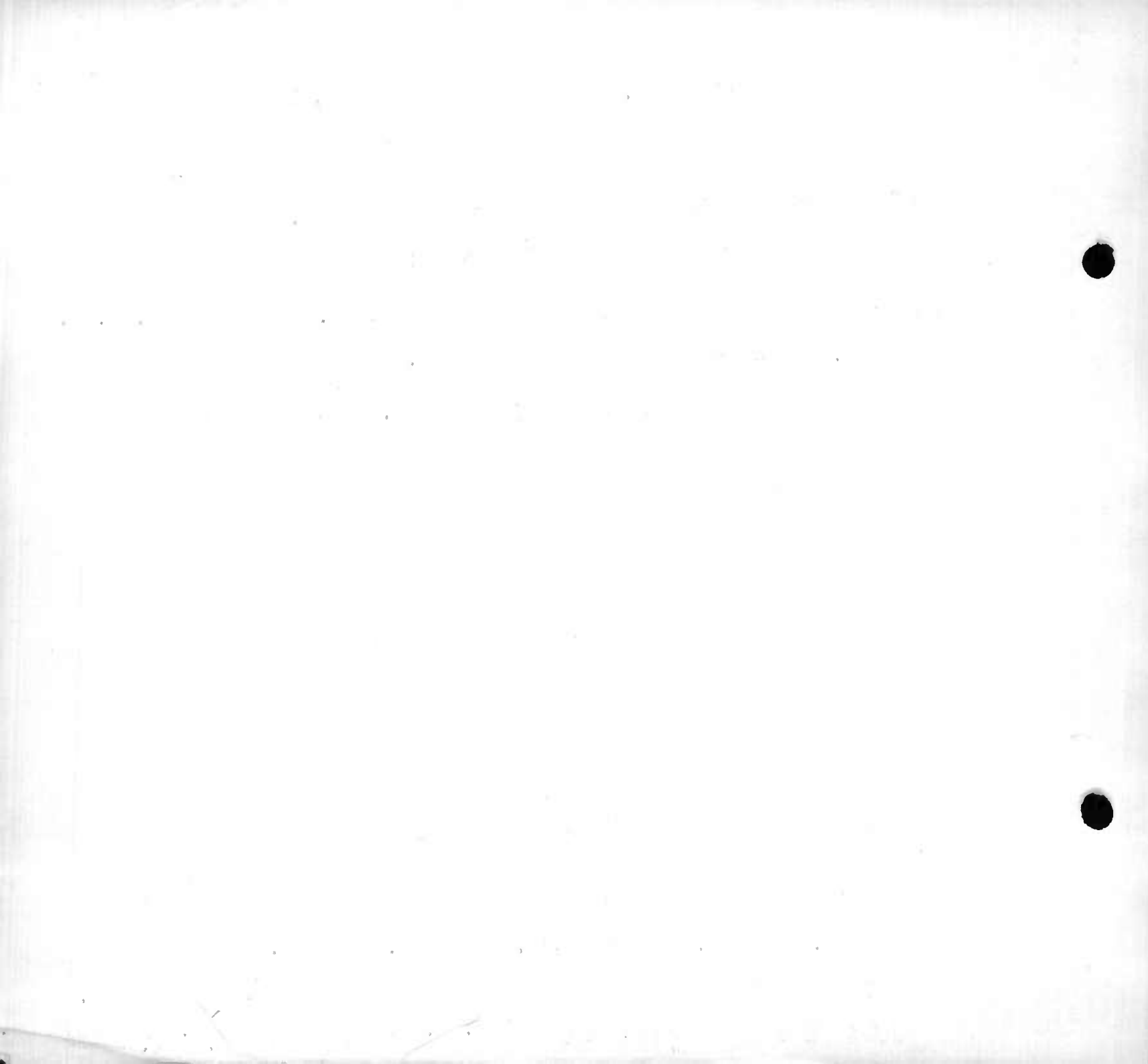




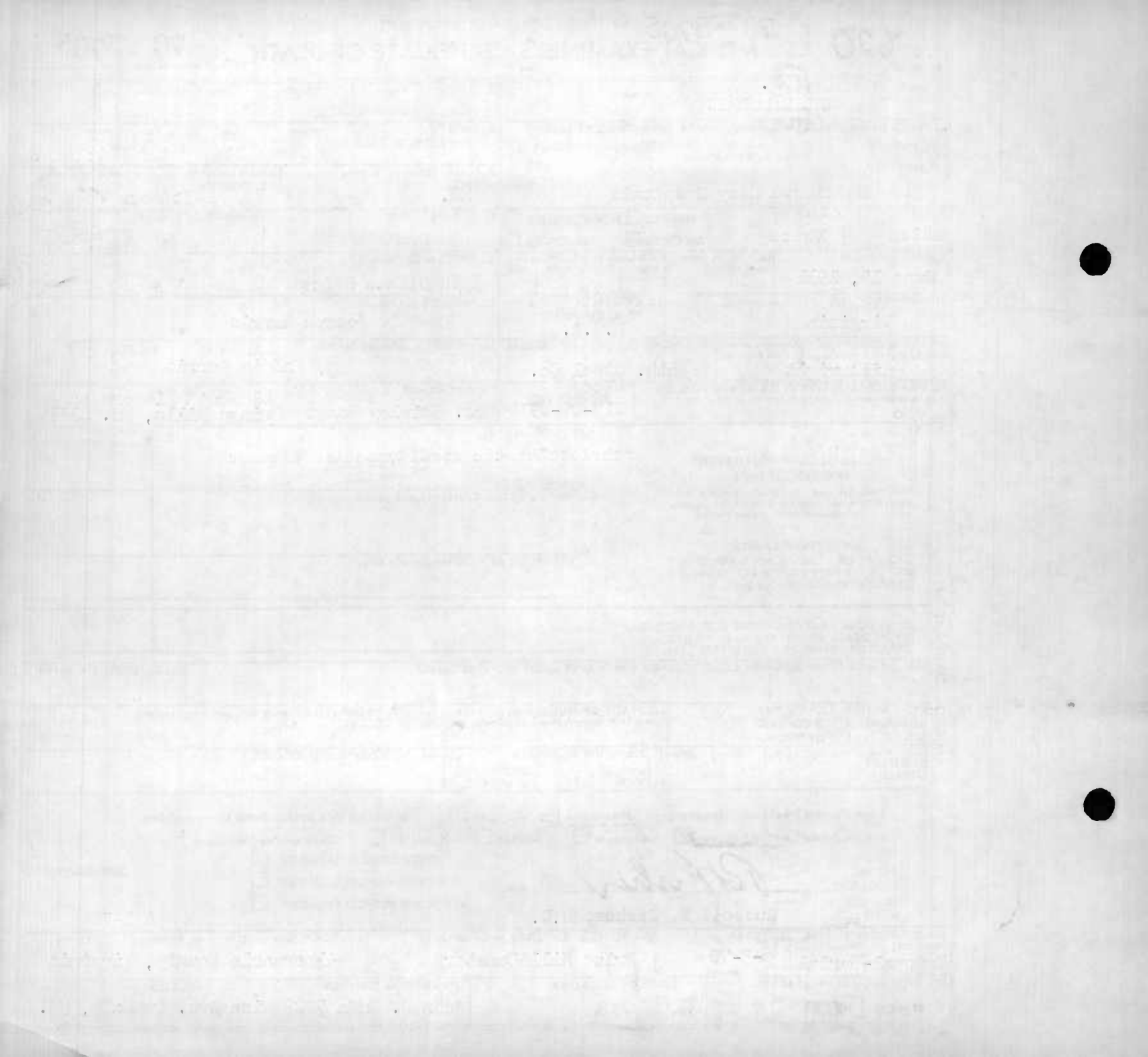
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5704</u>	
70 5704				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Caroline B. Thatcher		June 2, 1970 1:46 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 Anderson Nursing Home			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1504 Bolton St.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/1882	9. AGE (In years lost birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Walter C. Thatcher			14. MOTHER'S MAIDEN NAME Kate B. Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-7673		17. INFORMANT Howard R. Thatcher (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  412.34 250.9 Disease or condition directly leading to death  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure Hypertension HD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1955 to June 2, 1970 that (I) (we) last saw the deceased alive on June 1, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Louis P. Hamburger, Jr.			23B. DATE SIGNED 6/3/70		
23C. PHYSICIAN'S NAME (Type) Dr. Louis P. Hamburger, Jr.			23D. ADDRESS 1001 St. Paul St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. <u>M-620</u>					REG. NO. <u>70 5705</u>				
1. NAME OF DECEASED (Type or Print) <u>RALPH MORRIS</u>					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u>					3. DATE PRONOUNCED DEAD Month Day Year Hour <u>5 31 1970 1:20 A.M.</u>				
6. SEX <u>Male</u>					7. RACE <u>White</u>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					C. CITY OR TOWN <u>Dundalk</u>				
9. DATE OF BIRTH <u>June 17, 1911</u>					10. AGE (In years last birthday) <u>58</u>				
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>					14B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>				
15. MOTHER'S MAIDEN NAME <u>Maddie Morris</u>					16. FATHER'S NAME <u>Joseph Morris</u>				
17. SOCIAL SECURITY NO. <u>213-07-0914</u>					18. INFORMANT (Daughter) <u>Mrs. Shirley Bangs</u>				
19. <u>412.41</u>					20. <u>412.41</u>				
21. <u>412.41</u>					22. <u>412.41</u>				
23. <u>412.41</u>					24. <u>412.41</u>				
25. <u>412.41</u>					26. <u>412.41</u>				
27. <u>412.41</u>					28. <u>412.41</u>				
29. <u>412.41</u>					30. <u>412.41</u>				
31. <u>412.41</u>					32. <u>412.41</u>				
33. <u>412.41</u>					34. <u>412.41</u>				
35. <u>412.41</u>					36. <u>412.41</u>				
37. <u>412.41</u>					38. <u>412.41</u>				
39. <u>412.41</u>					40. <u>412.41</u>				
41. <u>412.41</u>					42. <u>412.41</u>				
43. <u>412.41</u>					44. <u>412.41</u>				
45. <u>412.41</u>					46. <u>412.41</u>				
47. <u>412.41</u>					48. <u>412.41</u>				
49. <u>412.41</u>					50. <u>412.41</u>				
51. <u>412.41</u>					52. <u>412.41</u>				
53. <u>412.41</u>					54. <u>412.41</u>				
55. <u>412.41</u>					56. <u>412.41</u>				
57. <u>412.41</u>					58. <u>412.41</u>				
59. <u>412.41</u>					60. <u>412.41</u>				
61. <u>412.41</u>					62. <u>412.41</u>				
63. <u>412.41</u>					64. <u>412.41</u>				
65. <u>412.41</u>					66. <u>412.41</u>				
67. <u>412.41</u>					68. <u>412.41</u>				
69. <u>412.41</u>					70. <u>412.41</u>				
71. <u>412.41</u>					72. <u>412.41</u>				
73. <u>412.41</u>					74. <u>412.41</u>				
75. <u>412.41</u>					76. <u>412.41</u>				
77. <u>412.41</u>					78. <u>412.41</u>				
79. <u>412.41</u>					80. <u>412.41</u>				
81. <u>412.41</u>					82. <u>412.41</u>				
83. <u>412.41</u>					84. <u>412.41</u>				
85. <u>412.41</u>					86. <u>412.41</u>				
87. <u>412.41</u>					88. <u>412.41</u>				
89. <u>412.41</u>					90. <u>412.41</u>				
91. <u>412.41</u>					92. <u>412.41</u>				
93. <u>412.41</u>					94. <u>412.41</u>				
95. <u>412.41</u>					96. <u>412.41</u>				
97. <u>412.41</u>					98. <u>412.41</u>				
99. <u>412.41</u>					100. <u>412.41</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

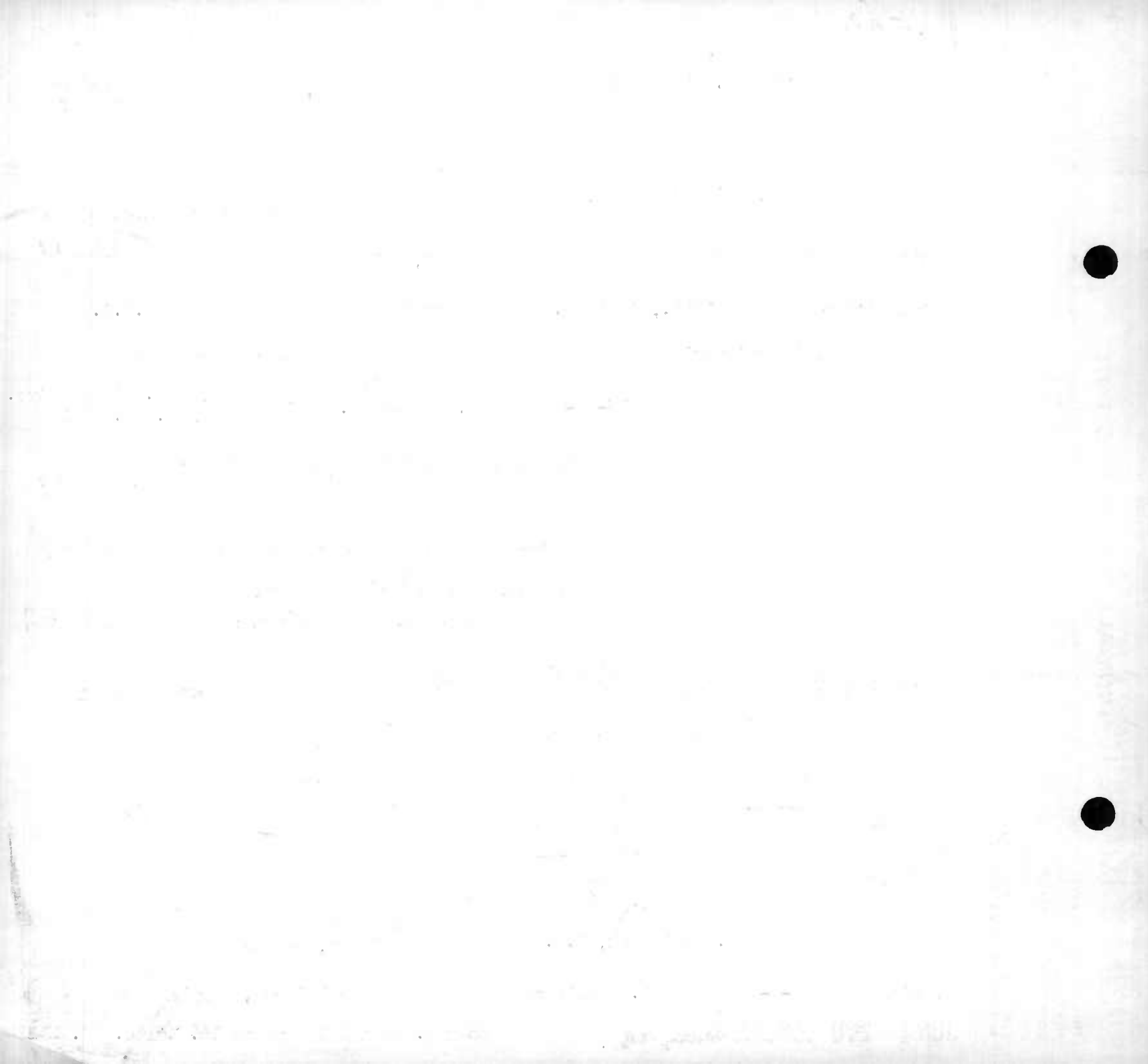
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		70 5706	
S-132		70 5706		70 5706		70 5706		70 5706	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Charles W. Spudick, Sr.				May 30, 1970					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland				Baltimore	
31 Baltimore City Hospital				C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
				Dundalk				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER				1825 Kinship Road	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 19, 1889		80	
								II Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Retired				Beth. Steel Co.				Poland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
U.S.A.				George Spudick		Anna ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS	
No				181-03-3786		Mrs. Violet Spudick		1825 Kinship Rd. Dundalk, Md.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				H.C.U.D.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
O				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from April 20 19 70 to April 20 19 70 that (I) (we) last saw the deceased alive on April 20 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
marcos Levin				6.2.70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Marcos Levin, M.D.				201 Wise Avenue					
				Dundalk, Maryland 21222					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		6-3-70		Parkwood		Parkville, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 4 1970		John J. Duda		7922 Wise Ave. Dundalk, Md.					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 5707</u>	
BIRTH NO. <u>M-520</u>		<u>70 5707</u>					
1. NAME OF DECEASED (Type or Print) <u>PETER J. MONIEWSKI</u>				2. DATE AND HOUR OF DEATH <u>June 1, 1970</u> <u>11:30</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 704 South Linwood Avenue</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>101</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>704 South Linwood Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1914</u>		9. AGE (In years last birthday) <u>55</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth., Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Moniewski</u>				14. MOTHER'S MAIDEN NAME <u>Mary Borkowska</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-5546</u>		17. INFORMANT (Wife) <u>Mrs. Frances S. Moniewski</u> ADDRESS <u>704 S. Linwood Ave. Balto. Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Chronic obstructive duodenitis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>(B) <del>Dist</del> Peritoneal adhesions</u> <u>(C) Partial gastrectomy for duodenal ulcer</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9-1-69</u> <u>9-1-69</u> <u>4-30-67</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>10-8-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Peritoneal Adhesions</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> No While At Work <input type="checkbox"/> <u>None</u>		21F. HOW DID INJURY OCCUR? <u>None</u>			
22. I certify that (I) ( <del>she/he</del> ) attended the deceased from <u>4-30-62</u> 19 <u>62</u> to <u>6-1-70</u> 19 <u>70</u> and that (I) ( <del>we</del> ) lost saw the deceased alive on <u>6-1-70</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>E. A. Schimunek</u>				23B. DATE SIGNED <u>6-9-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Emmanuel A. Schimunek, M.D.</u>				23D. ADDRESS <u>842 South East Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-5-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>2829 Hudson St. Balto. Md. 21224</u>	

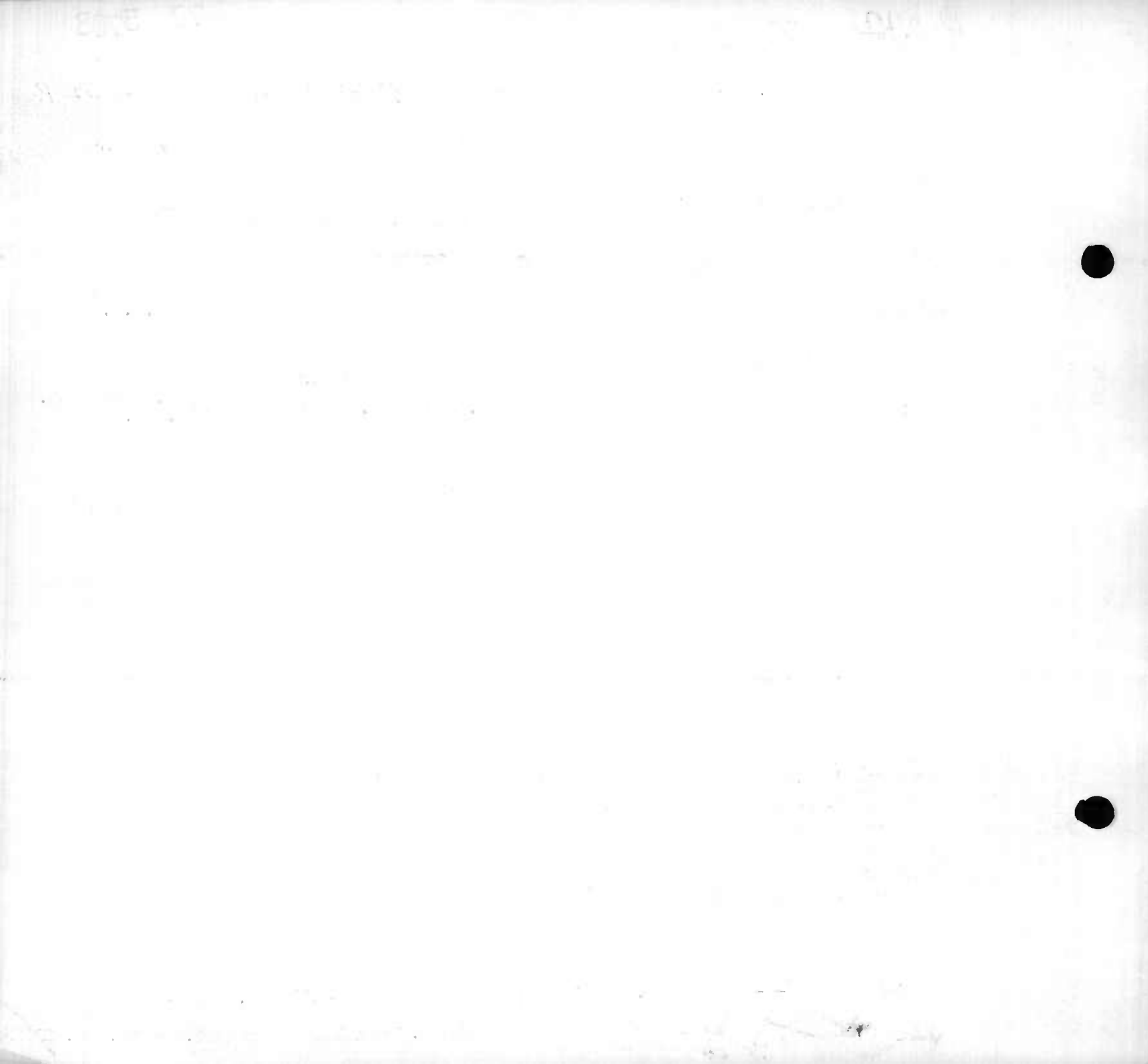




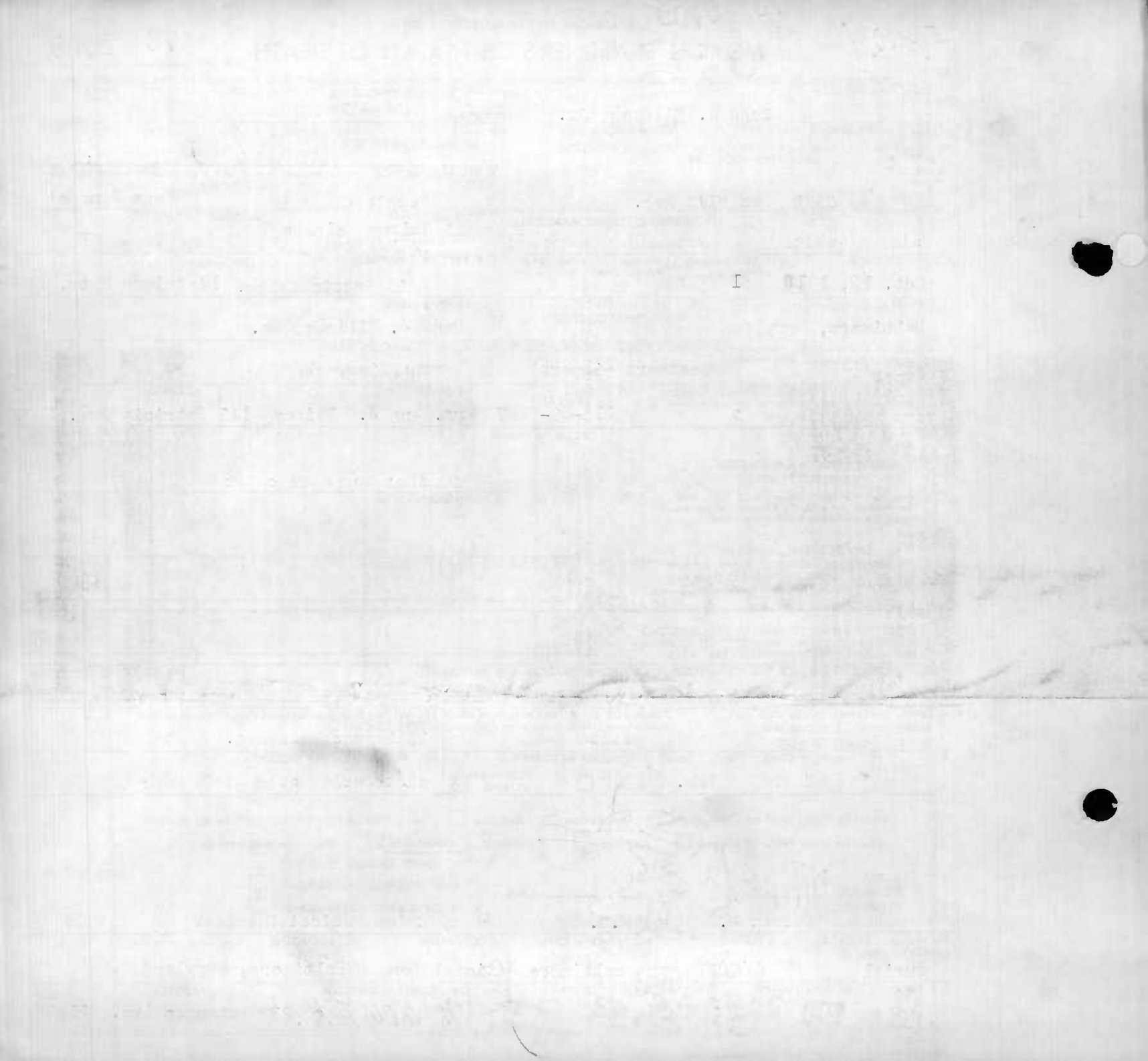
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>P-242</b>      <b>70 5708</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p><b>70 5708</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print)</p>		<p><b>2. DATE AND HOUR OF DEATH</b></p>	
		<p><b>POSLUSZNY, STANISLAUS H.</b></p>		<p><b>5.31.1970</b>      <b>2:52 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p>			
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b></p>		<p><b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b></p>		<p><b>A. STATE &amp; COUNTY</b></p>	
<p><b>35</b>      <b>CHURCH HOME and HOSPITAL</b></p>		<p><b>MARYLAND</b></p>		<p><b>105</b></p>	
		<p><b>C. CITY OR TOWN</b></p>		<p><b>D. INSIDE CITY LIMITS?</b></p>	
		<p><b>BALTIMORE</b></p>		<p><b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b></p>	
		<p><b>E. STREET AND NUMBER</b></p>			
		<p><b>311 S. DUNCAN ST. #21224</b></p>			
<p><b>5. SEX</b></p>		<p><b>6. RACE</b></p>		<p><b>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b></p>	
<p><b>M</b></p>		<p><b>W</b></p>		<p><b>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></b></p>	
<p><b>8. DATE OF BIRTH</b></p>		<p><b>9. AGE (in years last birthday)</b></p>		<p><b>10. IF UNDER 1 Yr. Months Days</b></p>	
<p><b>3/27/20</b></p>		<p><b>50</b></p>		<p><b>11. BIRTHPLACE (State or foreign country)</b></p>	
				<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p>	
<p><b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>MARYLAND</b></p>	
<p><b>CARPENTER</b></p>				<p><b>U.S.A.</b></p>	
<p><b>13. FATHER'S NAME</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p>			
<p><b>FRANK POSLUSZNY</b></p>		<p><b>ANNA SAS</b></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT (Brother)</b></p>	
<p><b>Yes</b></p>		<p><b>WW II</b></p>		<p><b>Mr. Joseph A. Posluszny</b></p>	
				<p><b>1025 S. Curley St. Balto. Md. 21224</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p>		<p><b>CAUSE OF DEATH</b></p>			
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p><b>1. GI bleeding due to cirrhosis liver</b></p>			
<p><b>ANTECEDENT CAUSES</b></p>		<p><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b></p>			
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>to cirrhosis liver</b></p>			
		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p>			
		<p><b>jaundice &amp; Hepatitis</b></p>			
		<p><b>(C) Cirrhosis liver probably an alcoholic basis for years.</b></p>			
<p><b>II</b></p>					
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY? (Yes or No)</b></p>	
<p><b>0</b></p>				<p><b>No</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b></p>		<p><b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b></p>		<p><b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b></p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b></p>		<p><b>21E. INJURY OCCURRED</b></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p>(Month) (Day) (Year) (Hour)</p>		<p><b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>5.31.1970</u> to <u>5.31.1970</u> that (I) (we) last saw the deceased alive on <u>5.31.1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b></p>				<p><b>23B. DATE SIGNED</b></p>	
<p><b>Abdus Samad</b></p>				<p><b>5/31/70</b></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b></p>				<p><b>23D. ADDRESS</b></p>	
<p><b>ABDUS SAMAD</b></p>				<p><b>Church Home Hospital Baltimore MD. 21231</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b></p>		<p><b>24B. DATE</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b></p>	
<p><b>Burial</b></p>		<p><b>6-4-70</b></p>		<p><b>St. Stanislaus</b></p>	
<p><b>24D. LOCATION (City, town, or county)</b></p>		<p><b>24E. STATE</b></p>			
<p><b>Baltimore, Maryland</b></p>		<p><b>Maryland</b></p>			
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p>		<p><b>25B. NAME OF REGISTRAR</b></p>		<p><b>25C. FUNERAL DIRECTOR</b></p>	
<p><b>JUN 4 1970</b></p>		<p><b>John J. Duda</b></p>		<p><b>2829 Hudson St. Balto. Md. 21224</b></p>	



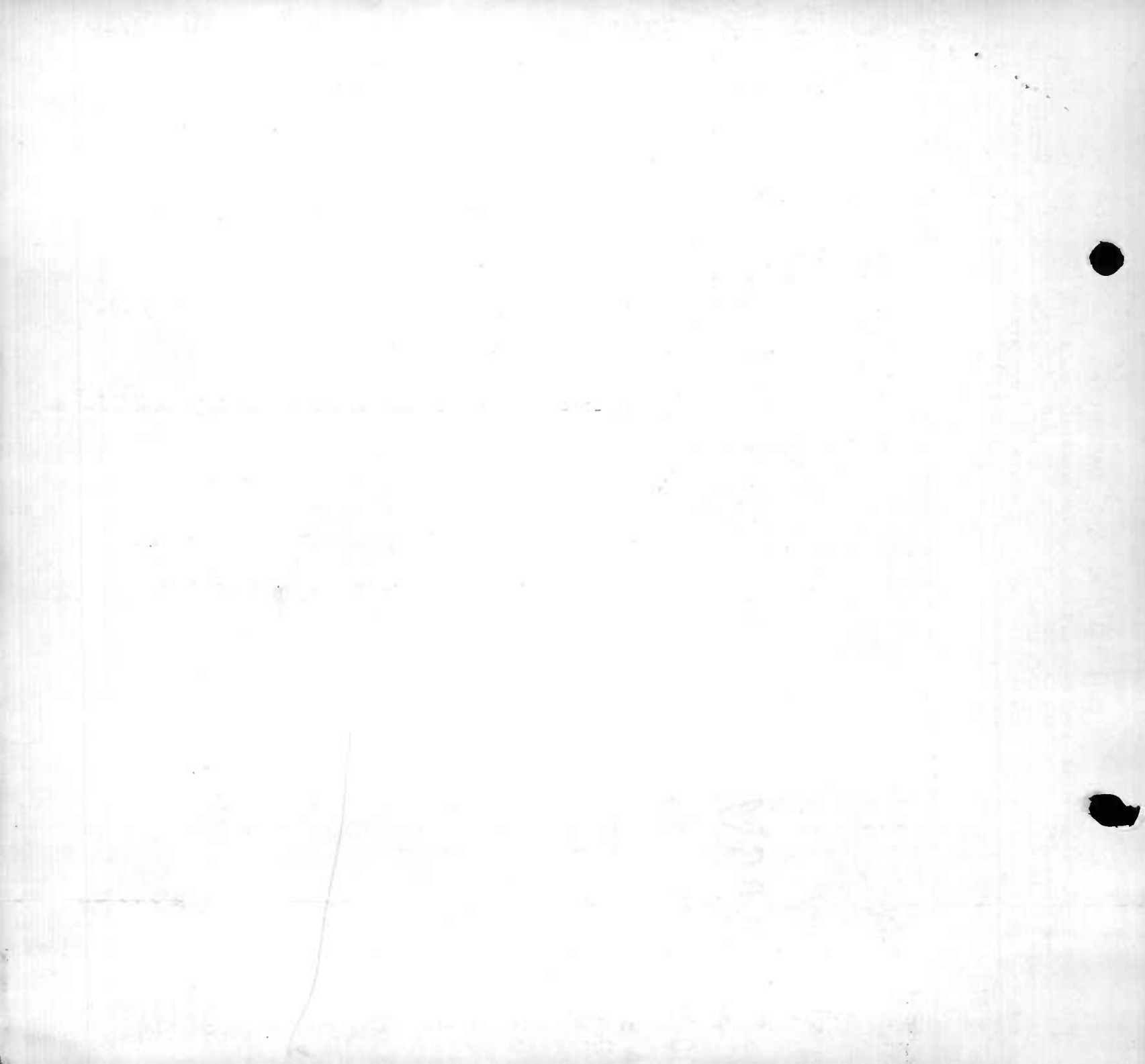
BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 5709			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) <b>Bond J. Ellison, Jr.</b>						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 2 70 10:00 a.m.</b>					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2312 Annapolis Ave.</b>						3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 2 70 10:00 a.m.</b>					
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
6. SEX <b>male</b>		7. RACE <b>white</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Linthicum Heights</b>		E. STREET AND NUMBER <b>113 Patricia Ave. Linthicum Hgts. 21090</b>			
9. DATE OF BIRTH <b>Oct. 12, 1918</b>		10. AGE (In years, lost birth day) <b>51</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>Bond J. Ellison, Sr.</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Westport Liquors</b>		15. MOTHER'S MAIDEN NAME <b>Bertha Ziegwerk</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W 2</b>					
17. SOCIAL SECURITY NO. <b>215-09-5887</b>		18. INFORMANT <b>Mrs. Ina J. Ellison</b>		ADDRESS <b>113 Patricia Ave. 21090</b>		19. CAUSE OF DEATH <b>E965 X 1</b>					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Gunshot wound of chest</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>NO</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>store</b>				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>2312 Annapolis Ave.</b>			
22D. TIME OF INJURY (Approx.) Month Day Year <b>6 2 70</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>shot during attempted hold-up</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>6/2/70</b>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6/5/70</b>				24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>			
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>McCall, F.H.</b>			
				ADDRESS <b>237 Patapsco Ave. 21225</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-200</b>		BALTIMORE CITY HEALTH DEPARTMENT		70 5710		CERTIFICATE OF DEATH		X		REG. NO. 70 5710	
1. NAME OF DECEASED (Type or Print) <b>Nina Ross</b>						2. DATE AND HOUR OF DEATH <b>June 1, 1970</b> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Hood Nursing Home</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3626 Valley Terrace Balto. Md. 21207</b>					
5. SEX <b>Female</b>		6. RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/29/92</b>		9. AGE (In years last birthday) <b>78</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Buyer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Genungs Store</b>		11. BIRTHPLACE (State or foreign country) <b>Minneapolis, Minn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Sheldon Leonard</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-01-8303</b>		17. INFORMANT ADDRESS <b>Mrs. Edward E. Jones Box 121A Hearnwood Rd. 21163</b>					
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ACUTE MYOCARDIAL INFARCTION -</b> <b>ACUTE SCLEROTIC PANCREATITIS -</b> <b>DISSEMINATED EMBOLIC PHLEBITIS -</b> <b>INSUFFICIENCY</b>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> 19 <b>70</b> to <b>6/1</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>6/1</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Loem Holm</b>						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>6/1/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Loem Holm</b>						23D. ADDRESS <b>5800 Edmonson Ave. Balt. Md 21208</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>				25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Rd. Randallstown</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
BIRTH NO. <span style="font-size: 1.5em;">H-230 70 5711</span>		70 5711	
M.E. CASE NO.		1	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Henry Hust</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6/1/70 8 P. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">48 Maryland General Hospital</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1701</span>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">Congress Hotel - W. Franklin Street</span>	
6. RACE <span style="font-size: 1.2em;">White</span>		E. DATE OF BIRTH <span style="font-size: 1.2em;">5/20/1885</span>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">85</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Ret. Electrical Appliance Salesman</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Germany</span>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Nicholas Hust</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">---</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-03-5049</span>	
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Gloria H. Abbott</span>		ADDRESS <span style="font-size: 1.2em;">115 Longdale Road - 210-93 Timonium, Md.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">157.8</span>		CAUSE OF DEATH <span style="font-size: 1.2em;">Bronchopneumonia, bilateral</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">CARCINOMA of Pancreas (body)</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Y-S</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">Y-S</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/27</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6/1</span> 19 <span style="font-size: 1.2em;">70</span> , that <span style="font-size: 1.2em;">They</span> last saw the deceased alive on <span style="font-size: 1.2em;">6/1</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Louis E. Gruyer</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">6/2/70</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/4/70</span>	
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Woodlawn Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 4 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Sterling Funeral Estate</span>		ADDRESS <span style="font-size: 1.2em;">736 Edmondson Ave. Catonsville, Md. 21228</span>	

306 W. Franklin St



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 5712	
B-620 70 5712				CERTIFICATE OF DEATH			
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) BROCHU, JOSEPH ADELAIDE				JUNE 1, 1970 7:45 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
40 ST AGNES HOSPITAL				MARYLAND BALTIMORE 5300			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				1201 SUMMIT AVE			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		04 25 95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday)		11. BIRTHPLACE (State or foreign country)	
RETIRED SEXTON		SACRED HEART CHURCH		75		NEW HAMPSHIRE	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SIMAII BROCHU				AMANDA Laflamme			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO -				706 01 4316		ST AGNES HOSP RECORDS-BALTO MD 21229	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				ACUTE MYOCARDIAL INFARCTION			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) A.S.C.V.D.			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 29 19 70 to JUNE 1 19 70							
that (I) (we) last saw the deceased alive on JUNE 1 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. Shams, M.D.				6-1-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A. SHAMS M.D.				ST AGNES HOSP BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/4/70		Woodlawn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 4 1970		Robert E. Taylor, M.D.		Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md 21038			

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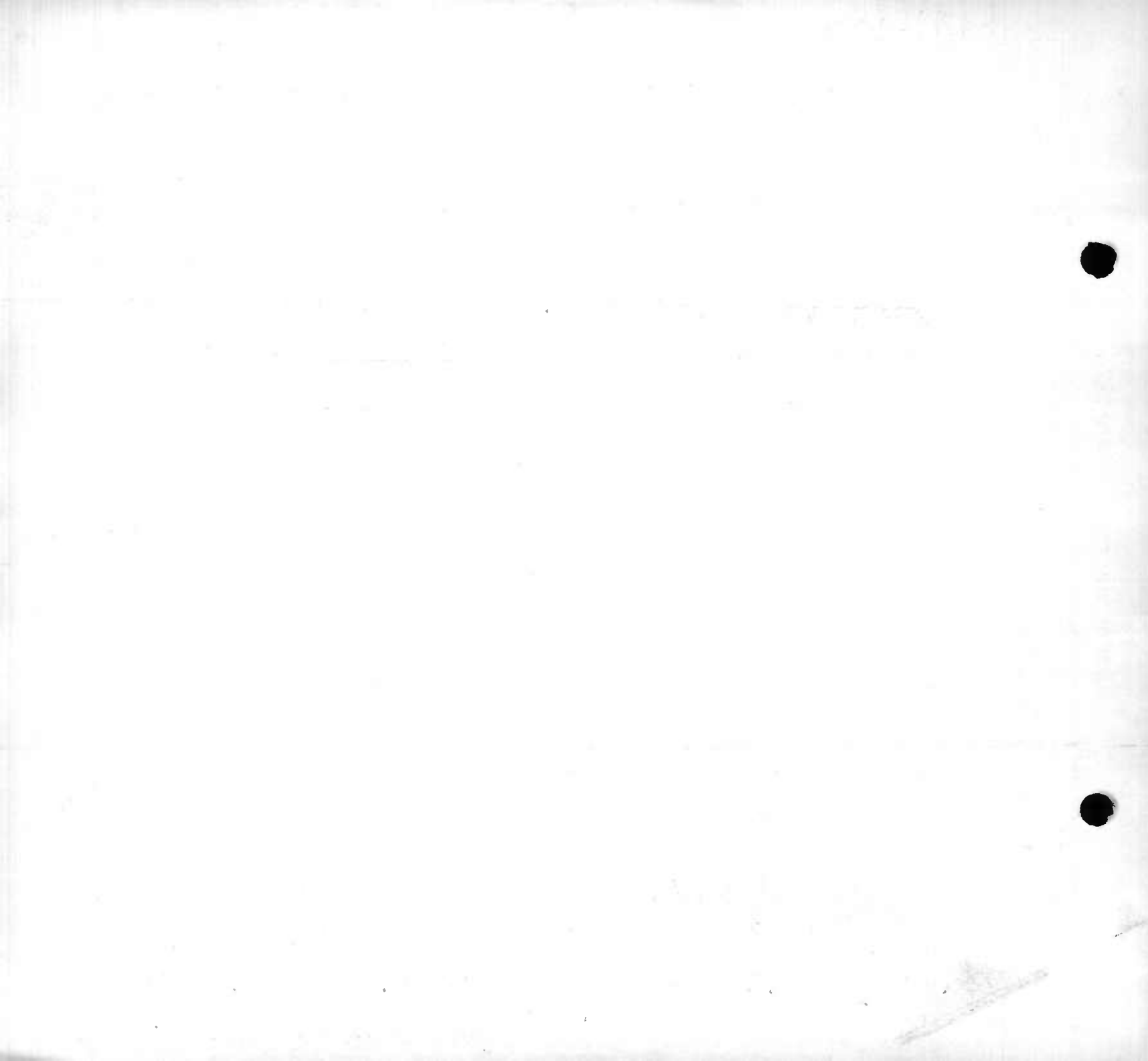
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

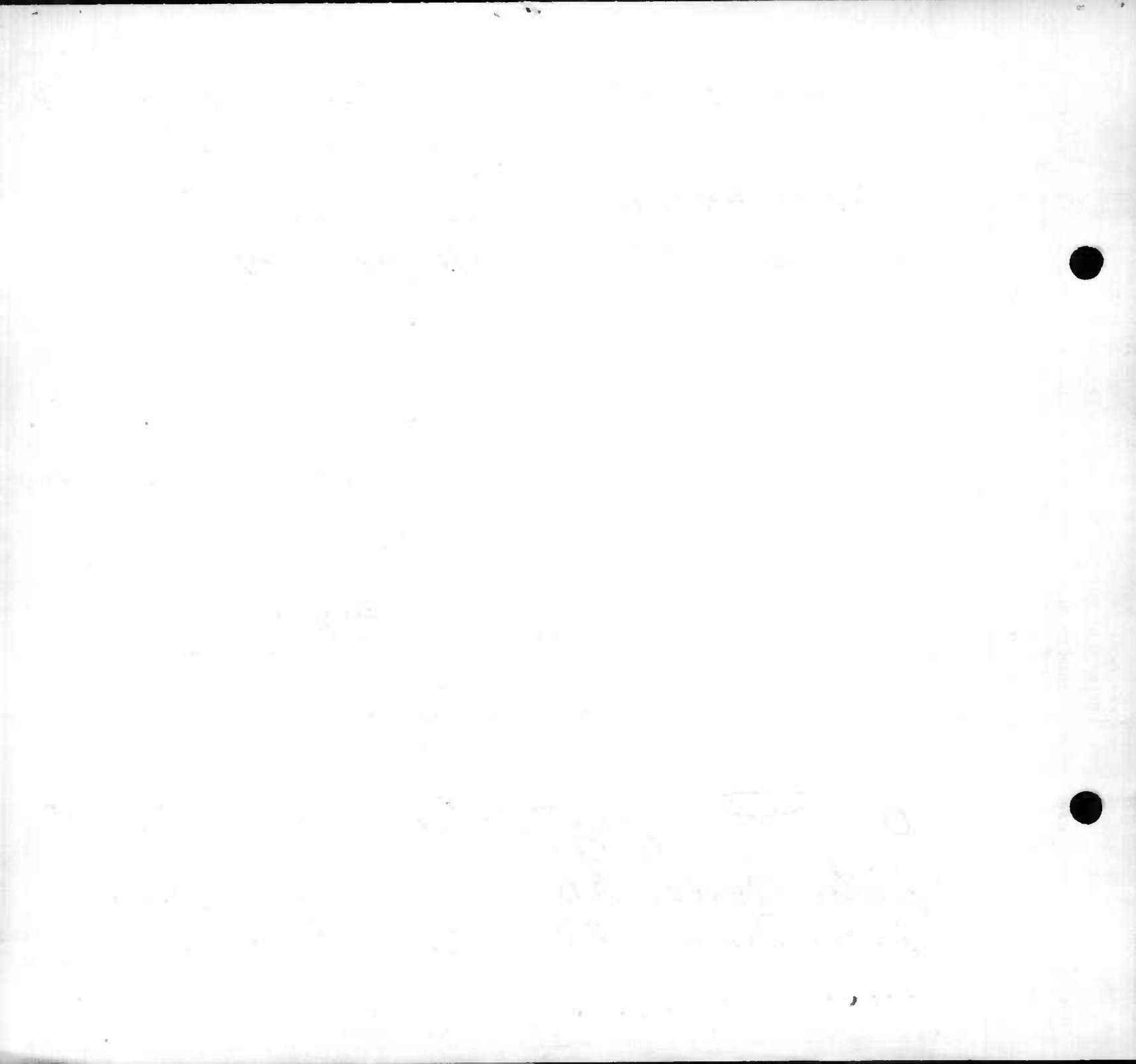
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5713	
M-200 70 5713		MCGHIE			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) John L. McGhie		2. DATE AND HOUR OF DEATH May 31, 1970 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Lutherville	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/4/03		9. AGE (in years last birthday) 67		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Chicago, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles McGhie		14. MOTHER'S MAIDEN NAME Elizabeth Isabell Gordon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 213-01-3366		17. INFORMANT Family records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma, undetermined primary site		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 31, 1970 to May 31, 1970 that (I) (we) last saw the deceased alive on May 31, 1970 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Boddie MD				23B. DATE SIGNED 5/31/70	
23C. PHYSICIAN'S NAME (Type) William L. Boddie MD				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jun. 4, 1970		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gdns, Cockeysville, Maryland	
24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR John Burns & Sons	
25C. FUNERAL DIRECTOR John Burns & Sons		25D. ADDRESS 610 York Rd.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

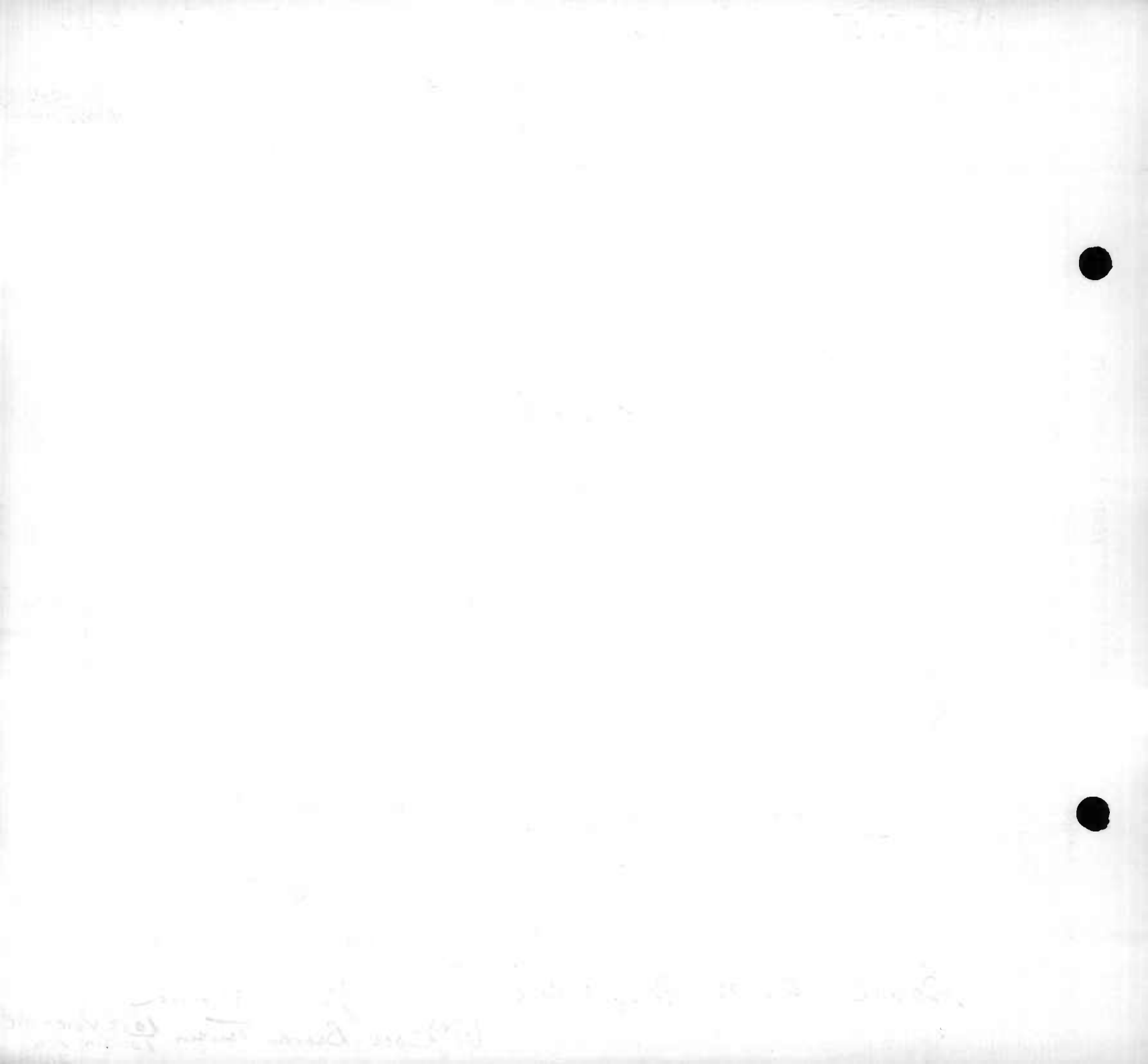
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-613		70 5714		70 5714	
1. NAME OF DECEASED (Type or Print) <b>HARRY KRAFT</b>			2. DATE AND HOUR OF DEATH <b>JUNE 2 1970 12:50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>833 W. 38th ST.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/23/98</b>	9. AGE (in years last birthday) <b>72</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		
11. BIRTHPLACE (State or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Kraft</b>			14. MOTHER'S MAIDEN NAME <b>Amelia Schwrit</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-07-6117</b>		
17. INFORMANT <b>A. Mrs. Helen Kraft - 833 W. 38th St.</b>			ADDRESS		
18. CAUSE OF DEATH <b>410.9+199.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Anemia, Chronic Abscess</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 9</b> 19 <b>70</b> to <b>JUNE 2</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>JUNE 2nd</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Victor Borden M.D.</b>			23B. DATE SIGNED <b>6/2/70</b>		23C. PHYSICIAN'S NAME (Type) <b>VICTOR BORDEN M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6/6/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>
24D. LOCATION <b>Baltimore</b>			24E. ADDRESS <b>Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>			25B. NAME OF REGISTRAR <b>Ann Donovan</b>		
25C. FUNERAL DIRECTOR <b>Ann Donovan</b>			ADDRESS <b>3818 Roland Ave.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-535		70 5715		BALTIMORE CITY HEALTH DEPARTMENT		70 5715	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SNYDEMAN, LAURA ELLEN				June 2nd, 1970 3.00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				COCKEYSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				BONNIE BLINK, COCKEYSVILLE, MD. 21030			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		07-27-89	
						9. AGE (In years last birthday) 80	
						If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
NONE				PENNSYLVANIA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ALBERT O. EMIG				MARGARET GIVENS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				20-05-2895		FRANK SMITH MD. MASONIC HOMES	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE MESENTERIC VASCULAR OCCLUSION							
DUE TO, OR AS A CONSEQUENCE OF:							
(B) GENERALIZED ARTERIOECCLEROSIS							
DUE TO, OR AS A CONSEQUENCE OF:							
(C) GIANT GASTRIC ULCER							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6/2/70		SHOCK					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 13th 1970 to June 2nd 1970 that (I) (we) lost saw the deceased alive on June 2nd 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Cabrera M.D.				June 2nd, 1970			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. CABRERA M.D.				UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-5-70		Prospect Hill		York, Penna	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 4 1970		Wm. C. Brooks		Wm. C. Brooks		1030 York Rd. Towson, Md.	

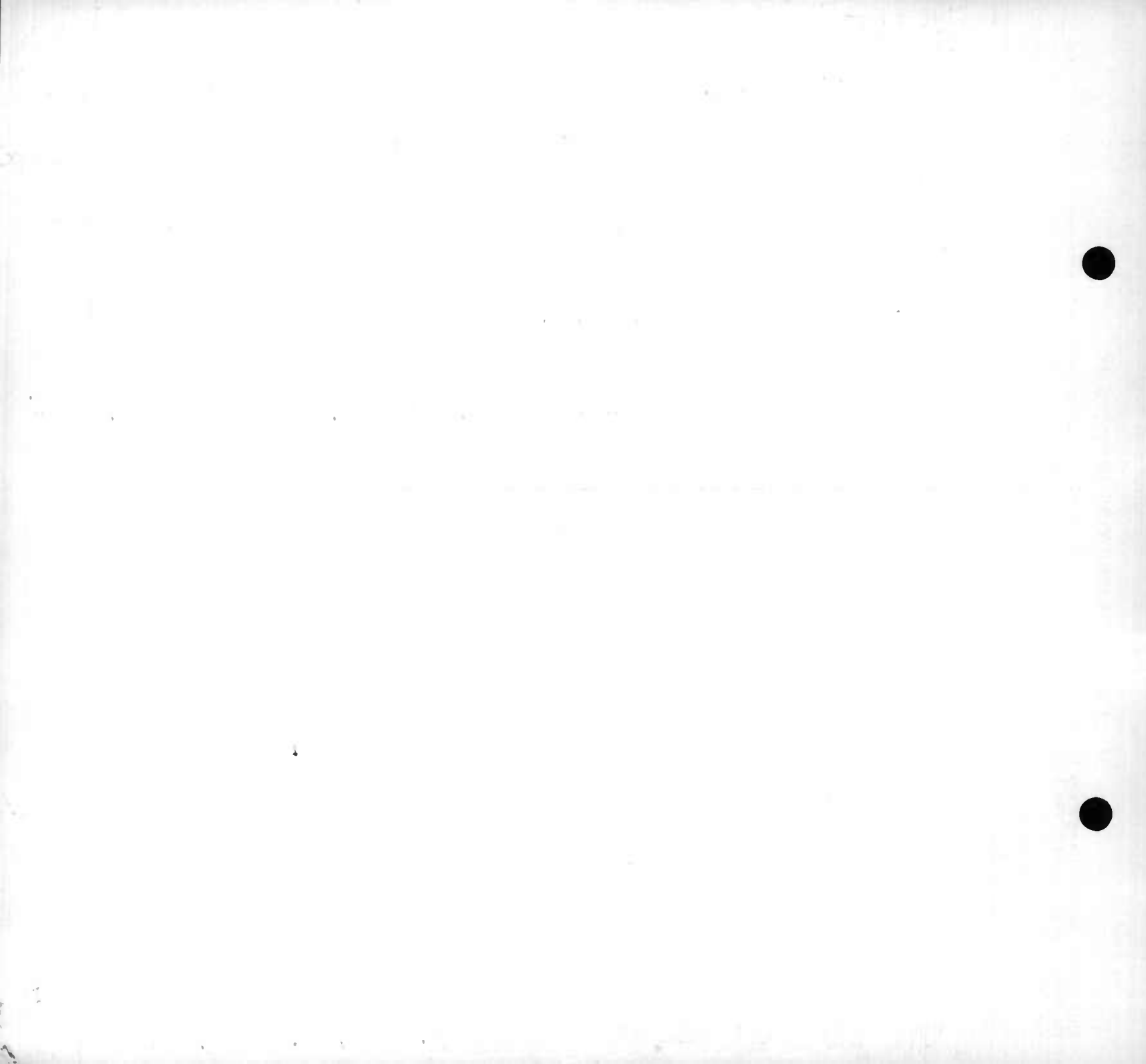




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-325 70 5716		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5716	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARION C. HUTCHINSON</b>		2. DATE AND HOUR OF DEATH <b>June 2, 1970 10:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b> <b>48</b>		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3107 E. FAIRMOUNT AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-22-96</b>	9. AGE (in years last birthday) <b>73</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Side Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cont'l. Can. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>	
13. FATHER'S NAME <b>WILLIAM HUTCHINSON</b>		14. MOTHER'S MAIDEN NAME <b>JULIA HENRY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO. <b>215-05-5508A</b>		17. INFORMANT <b>Mrs. Rebecca M. Hutchinson</b> ADDRESS <b>mount Ave. 3107 E. Fair-</b>	
18. <b>319.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>PNEUMONIA</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Obstructive Lung Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Obstructive Lung Disease</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PARY (A). <b>Gastro-intestinal Bleeding</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>5-30-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-30-70</b> to <b>6-2-70</b> that (I) (we) last saw the deceased alive on <b>6-2-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gregorio Garzon MD</b> DEGREE		23B. DAY SIGNED <b>6-2-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Garzon</b>	
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/5/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE RECD BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b> ADDRESS <b>3000 E. Baltimore St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5717</u>	
BIRTH NO. <u>70 5717</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ESTELLA A. HOBBS</u>		2. DATE AND HOUR OF DEATH <u>JUNE 2, 1970</u> <u>7:40 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>903</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home &amp; Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3539 OLD YORK RD.</u>			
5. SEX <u>F.</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4. 20. 1912</u>	9. AGE (in years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>THOMAS BIDEN</u>		14. MOTHER'S MAIDEN NAME <u>Annie B. NARER</u> 2327 HAMMONDS FERRY RD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>911-18-2332</u>		17. INFORMANT <u>MARGARET BIDEN</u> ADDRESS <u>3539 Old York Rd.</u>	
18. <u>571.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PORTAL CIRRHOSIS &amp; ASCITES</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CHRONIC ALCOHOLISM</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u> <u>5 YRS.</u> <u>20 YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>5. 29.</u> 19 <u>70</u> to <u>6. 2</u> 19 <u>70</u> that <u>(1)</u> (we) last saw the deceased alive on <u>6. 2</u> 19 <u>70</u> and that <u>(1)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Roberto A. Mendez</u>		23B. DATE SIGNED <u>6/2/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERTO A. MENDEZ, M.D.</u>	
23D. ADDRESS <u>100 N. Broadway St. Baltimore, Md. 21231</u>		23E. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-5-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION <u>Washington Blvd. Howard Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 4 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. ADDRESS <u>4107 Wilkens Ave. 21220</u>			

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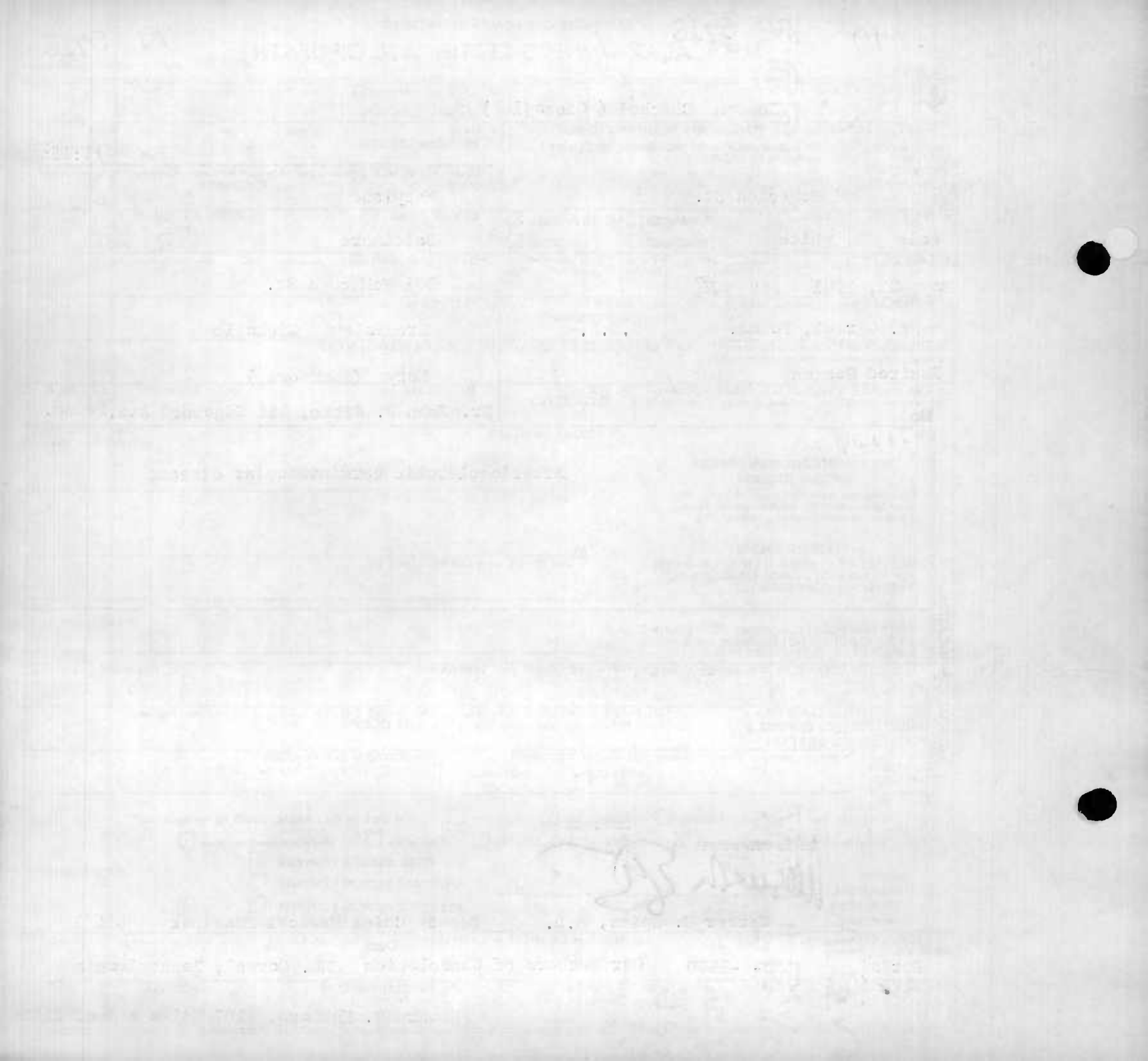
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5718

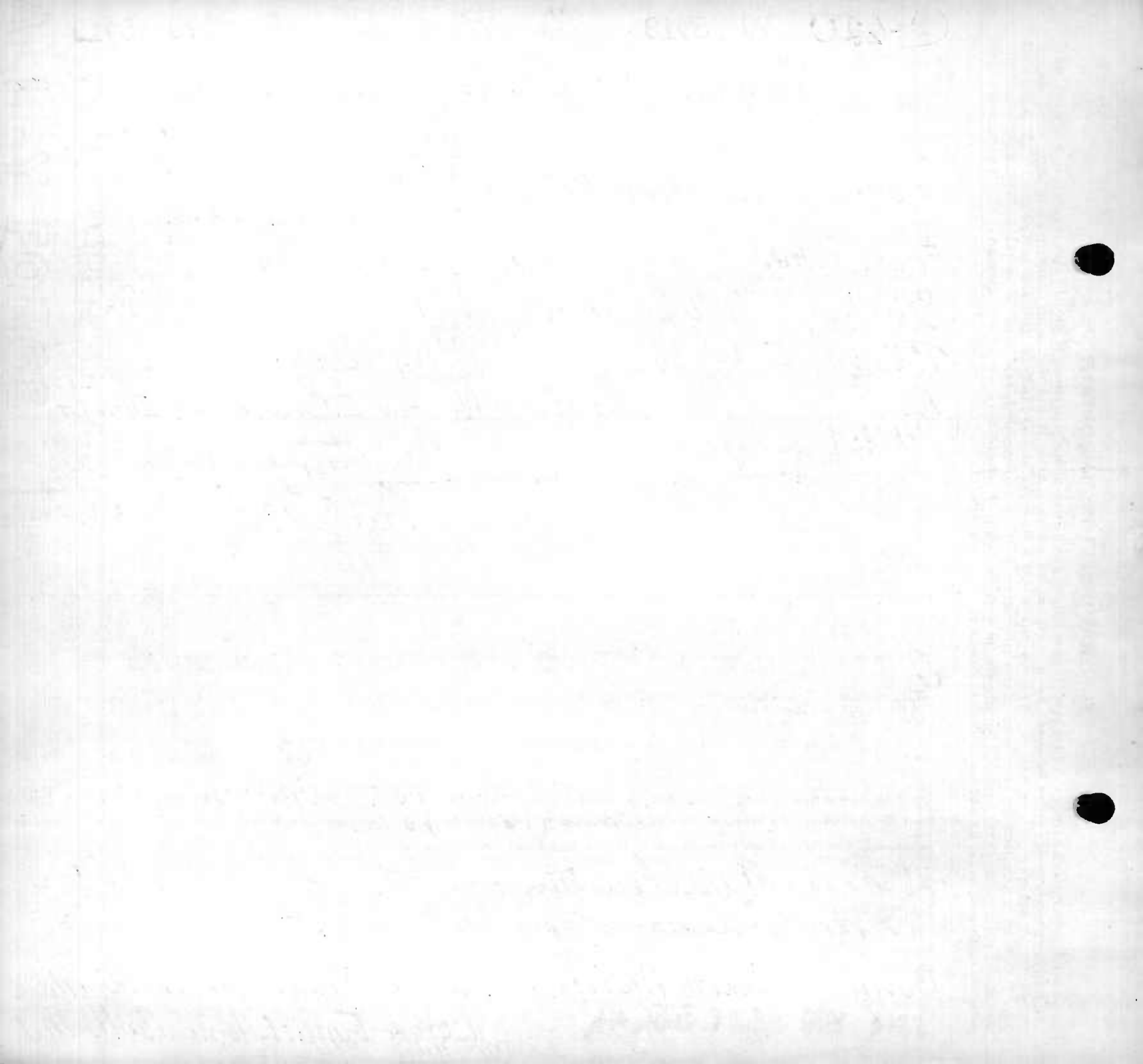
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joseph Chuckel ( Ciokajlo )		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 301 McMechen St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 1 70 11:15a M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1401	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 22, 1901		10. AGE (In years last birthday) 69 XX		E. STREET AND NUMBER 301 McMechen St.	
11. BIRTHPLACE (State or foreign country) Mt. Carmel, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bronislaw Ciokajlo	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seaman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary ( Unknown )	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. John J. Sitko, 411 Edgewood Ave. Lansdale Penna.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED 6/2/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-6-1970		24C. NAME OF CEMETERY or CREMATORY Our Mothers of Consolation Cem	
24D. LOCATION (City, town, or county) (State) Mt. Carmel, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Gentry, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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C-620 70 5719		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5719	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Virginia G. Crouse</i>		2. DATE AND HOUR OF DEATH <i>May 30 1970 7 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2757</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>002906 E Northern Pkwy</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>2906 E Northern Pkwy</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>3 Dec 1913</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frank E Webb</i>		14. MOTHER'S MAIDEN NAME <i>Mary Davis</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215 323468</i>		17. INFORMANT <i>Newton E Crouse</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i> <i>ASCVD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour?</i> <i>3 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 10 1967</i> to <i>May 30 1970</i> , that (I) (we) last saw the deceased alive on <i>May 26 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leonard Wallerstein</i>				23B. DATE SIGNED <i>6/2/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>LEONARD WALLERSTEIN MD</i>				23D. ADDRESS <i>848 W 36th</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3 June 70</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Mem Pk</i>	
24D. LOCATION <i>Taylor Ave Baltimore Md</i>		24E. NAME of REGISTRAR <i>Robert E. Taylor MD</i>		24F. FUNERAL DIRECTOR <i>Burger Funeral Home</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 4 1970</i>		25B. NAME of REGISTRAR <i>Robert E. Taylor MD</i>		25C. FUNERAL DIRECTOR <i>Burger Funeral Home</i>	

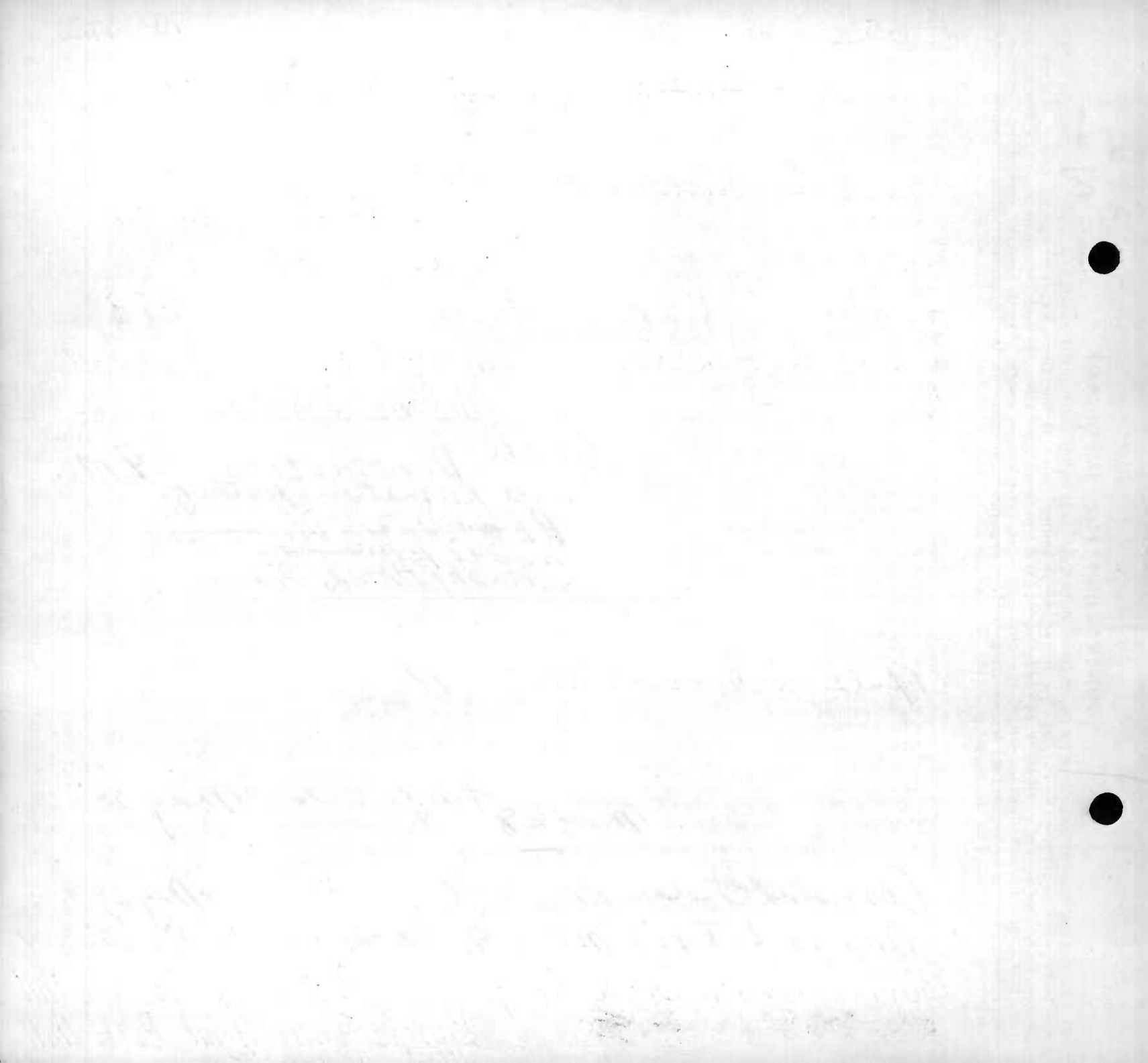




# FUNERAL DIRECTOR: IMPORTANT

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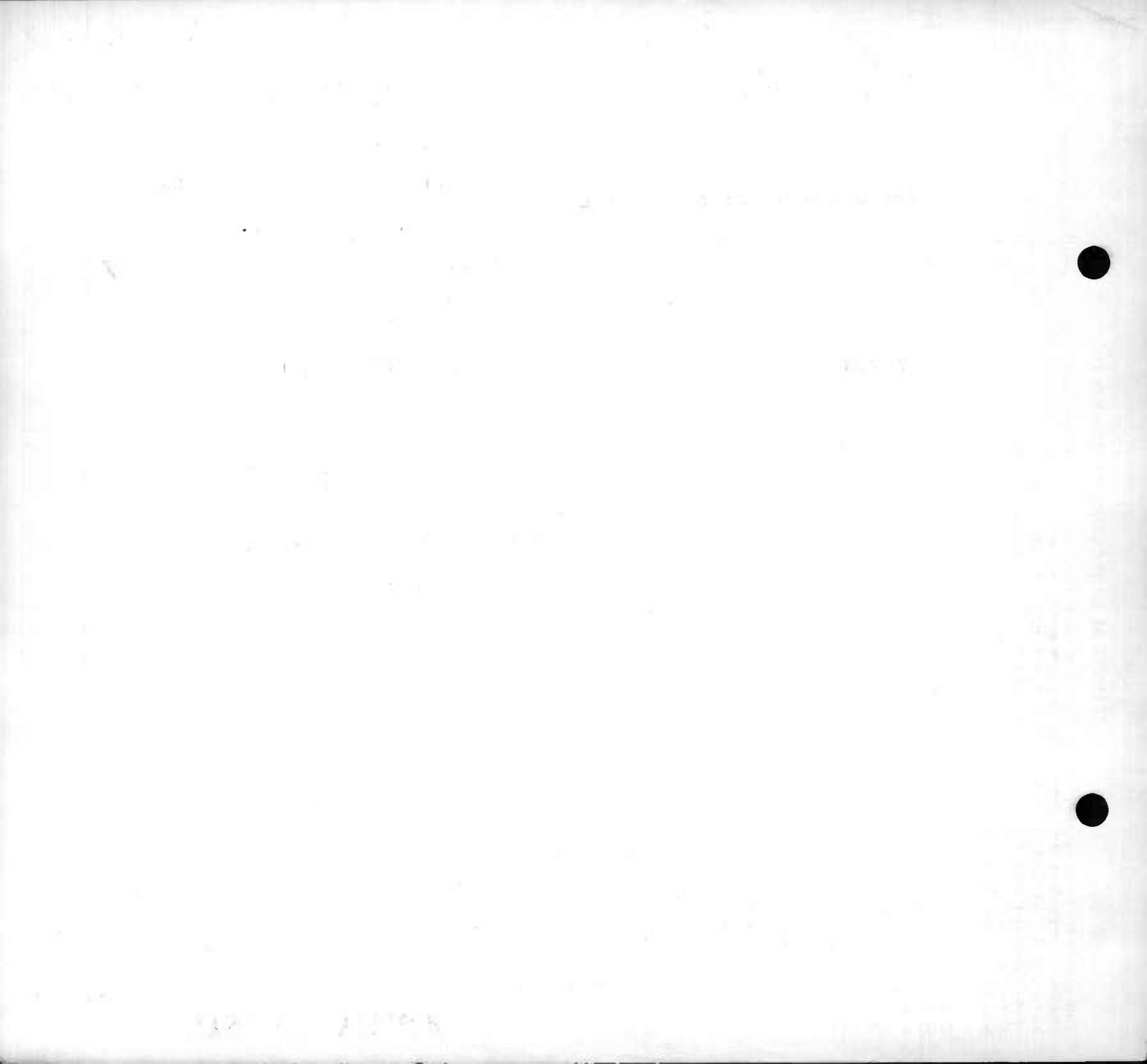
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5720</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">H-652</span>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <span style="font-size: 1.5em;">00237 E Belvedere Ave</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.5em;">May 29 1970</span>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.5em;">Ada Elizabeth Hornsby</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.5em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">2748</span>			
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">00237 E Belvedere Ave</span>		<b>C. CITY OR TOWN</b> <span style="font-size: 1.5em;">Balto</span>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>5. SEX</b> <span style="font-size: 1.5em;">Female</span>		<b>6. RACE</b> <span style="font-size: 1.5em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Auditor</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">US Government</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">11 Dec 84</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.5em;">Robert N Hornsby</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.5em;">Mary Catherine Lowman</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">85</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes/no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.5em;">-</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.5em;">Md</span>	
<b>17. INFORMANT</b> <span style="font-size: 1.5em;">Minnie I Smith</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">USA</span>		<b>ADDRESS</b> <span style="font-size: 1.5em;">same</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>A. IMMEDIATE CAUSE</b> <span style="font-size: 1.5em;">Acute DIVERTICULITIS</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">with perforation &amp; peritonitis</span> <b>B. REASON FOR DIVERTICULITIS</b> <span style="font-size: 1.5em;">PERFORATED DIVERTICULUM</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">CORONARY ARTERY DISEASE</span> <b>C. CORONARY ARTERY DISEASE</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">4 Mo.</span>			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.5em;">April 25 1970</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.5em;">diverticulitis</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.5em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notly medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.5em;">Feb 10 1970</span> <b>to</b> <span style="font-size: 1.5em;">May 28 1970</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.5em;">May 28 1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Arnold L. Field M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">May 29 1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em;">ARNOLD L. FIELD M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">901 CATHEDRAL ST BALTIMORE MD</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.5em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.5em;">June 7 1970</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.5em;">Druid Ridge</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.5em;">Pikesville Balto Co Md</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">JUN 4 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">Robert E. Taylor R.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.5em;">Burger Funeral Home Balto Md</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 5721</b>	
<b>CERTIFICATE OF DEATH</b>			
BIRTH NO. <b>70-09480 5721</b>		2. DATE AND HOUR OF DEATH <b>6/1/70 6:00 PM</b>	
1. NAME OF DECEASED (Type or Print) <b>Said, BB of Jeanette</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>807</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>33 THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		E. STREET AND NUMBER <b>1925 E. HOFFMAN ST.</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/70 10:25</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>35</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Johns Hopkins Hospital</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>STEVEN</b>		14. MOTHER'S MARDEN NAME <b>JEANETTE HARRIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Acidosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Respiratory Distress Syndrome</b> <b>Prematurity</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> 19 <b>70</b> to <b>6/1</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/1</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jay W. Pettigrew M.D.</b>		23B. DATE SIGNED <b>6/1/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jay W. Pettigrew M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6/2/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Johns Hopkins Hospital</b>		24D. LOCATION (City, town, or county) (State) <b>601 N Broadway Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Rebecca Kelly</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
<b>HOSPITAL DISPOSAL</b>			



# FUNERAL DIRECTOR: IMPORTANT

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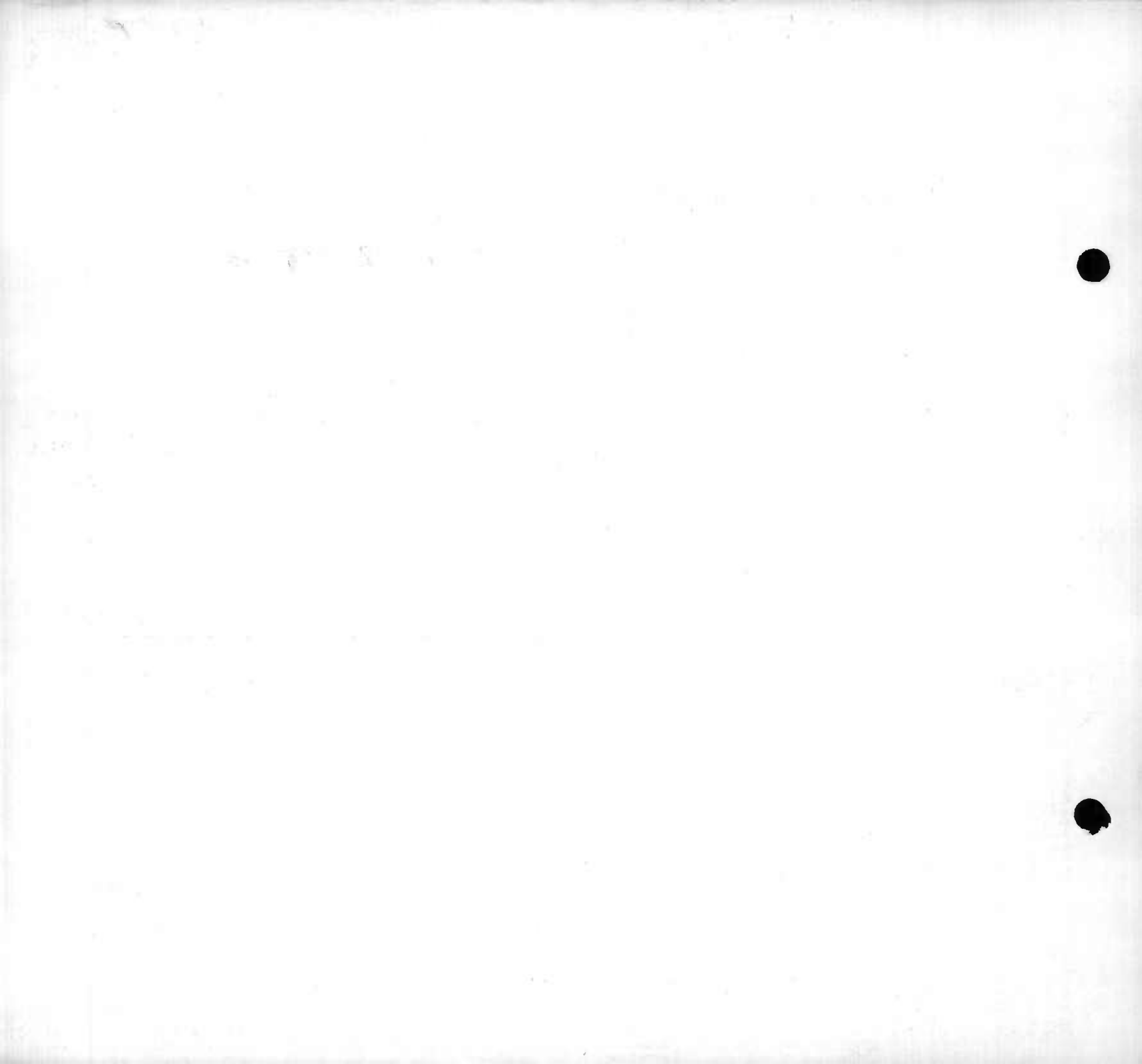
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5722</u>	
BIRTH NO. <u>A-536</u>		70 5722		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Andrew, Dock</u> (Andrews)			2. DATE AND HOUR OF DEATH <u>6-2-70</u> <u>4:30</u> A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Divison Street</u> <u>Baltimore, Maryland 21217</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1403</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2226 Druid Hill Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-96</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. C., Chatham</u>	
13. FATHER'S NAME <u>Dock Andrews</u>			14. MOTHER'S MAIDEN NAME <u>Lucy Andrews</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>242-28-5006</u>		17. INFORMANT <u>M's Vivian Porter-Friend</u>	
				ADDRESS <u>Same</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esophageal, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 Hours</u> <u>Unknown</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-3-70</u> 19 to <u>6-2-70</u> 19 that (I) (we) last saw the deceased alive on <u>6-2-70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot, M.D.</u>			23B. DATE SIGNED <u>June 2, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT, M.D.</u>			23D. ADDRESS <u>1514 Divison Street Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-6-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Terrells Chapel Ch. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Chatham Co., North Carolina</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>MORTON &amp; DYETT F.H.</u>	
25C. FUNERAL DIRECTOR <u>MORTON &amp; DYETT F.H.</u>		25D. ADDRESS <u>1701 Laurens Street</u>			



# FUNERAL DIRECTOR: IMPORTANT

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M-60070 5723		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5723	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IOLEIE MAYER (Iola)</b>		2. DATE AND HOUR OF DEATH <b>6-2-70 3:37 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>947 BENNETT ROAD</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-02</b>	9. AGE (in years last birth day) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ROBERT SANDERS</b>		14. MOTHER'S MAIDEN NAME <b>JANIE - ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>- 0 -</b>		17. INFORMANT <b>Mr. Roscoe Mayer 947 Bennett Place</b>	
18. <b>10-9-12509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>due to ACUTE MYOCARDIAL INFARCTION</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>due to ASWD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>DIABETES MELLITUS</b>		<b>years</b>	
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-1-1970</b> to <b>6-2-1970</b> that (I) (we) last saw the deceased alive on <b>6-2-1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gregorio Marfori MD</b>				23B. DATE SIGNED <b>6-3-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>GREGORIO MARFORI MD</b>				23D. ADDRESS <b>827 Linden Ave. Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/6/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION <b>Maryland</b>		24F. LOCATION <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Moorton &amp; Dyett F.H.</b>	
25D. ADDRESS <b>1701 Laurens St.</b>					



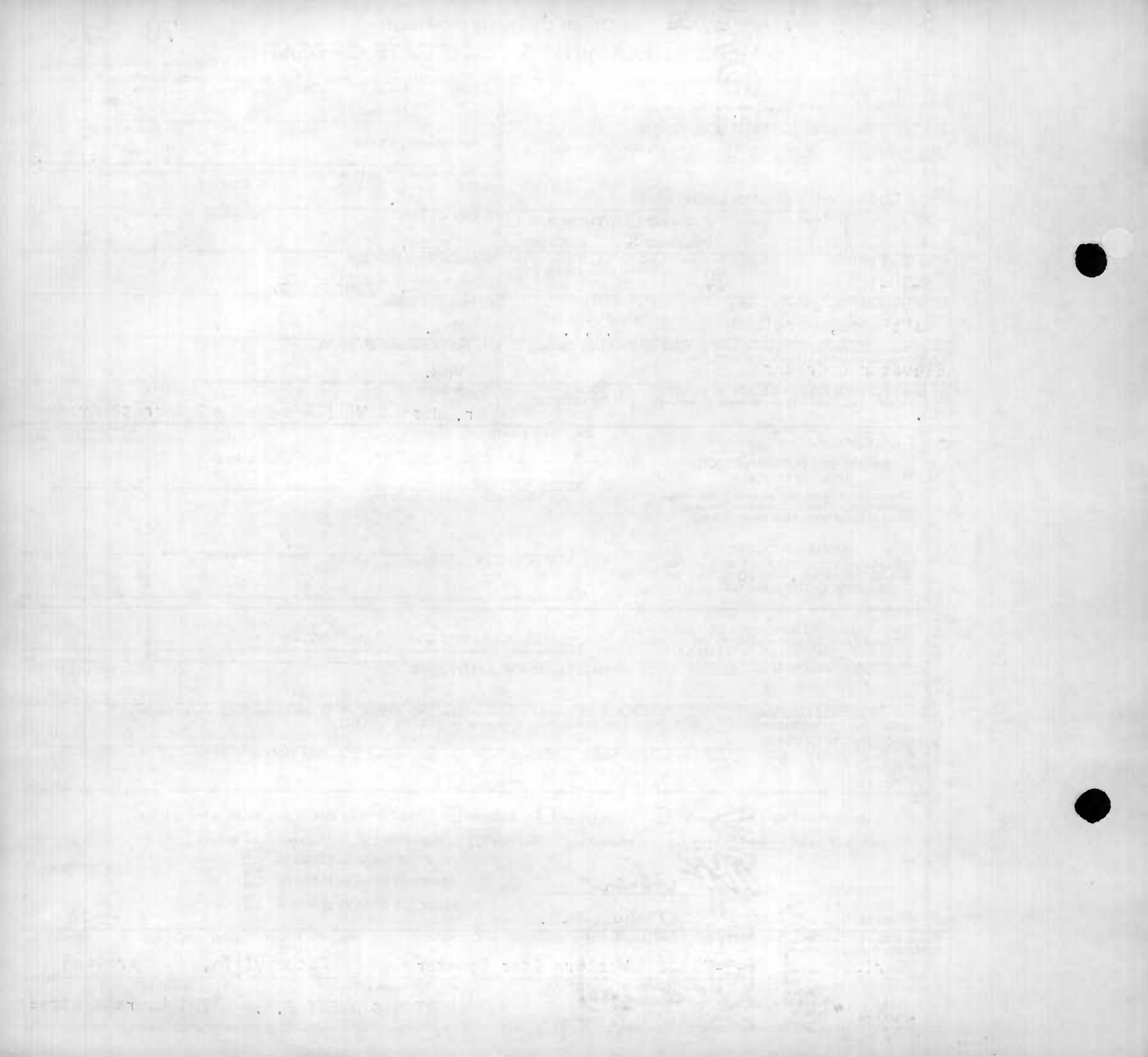


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

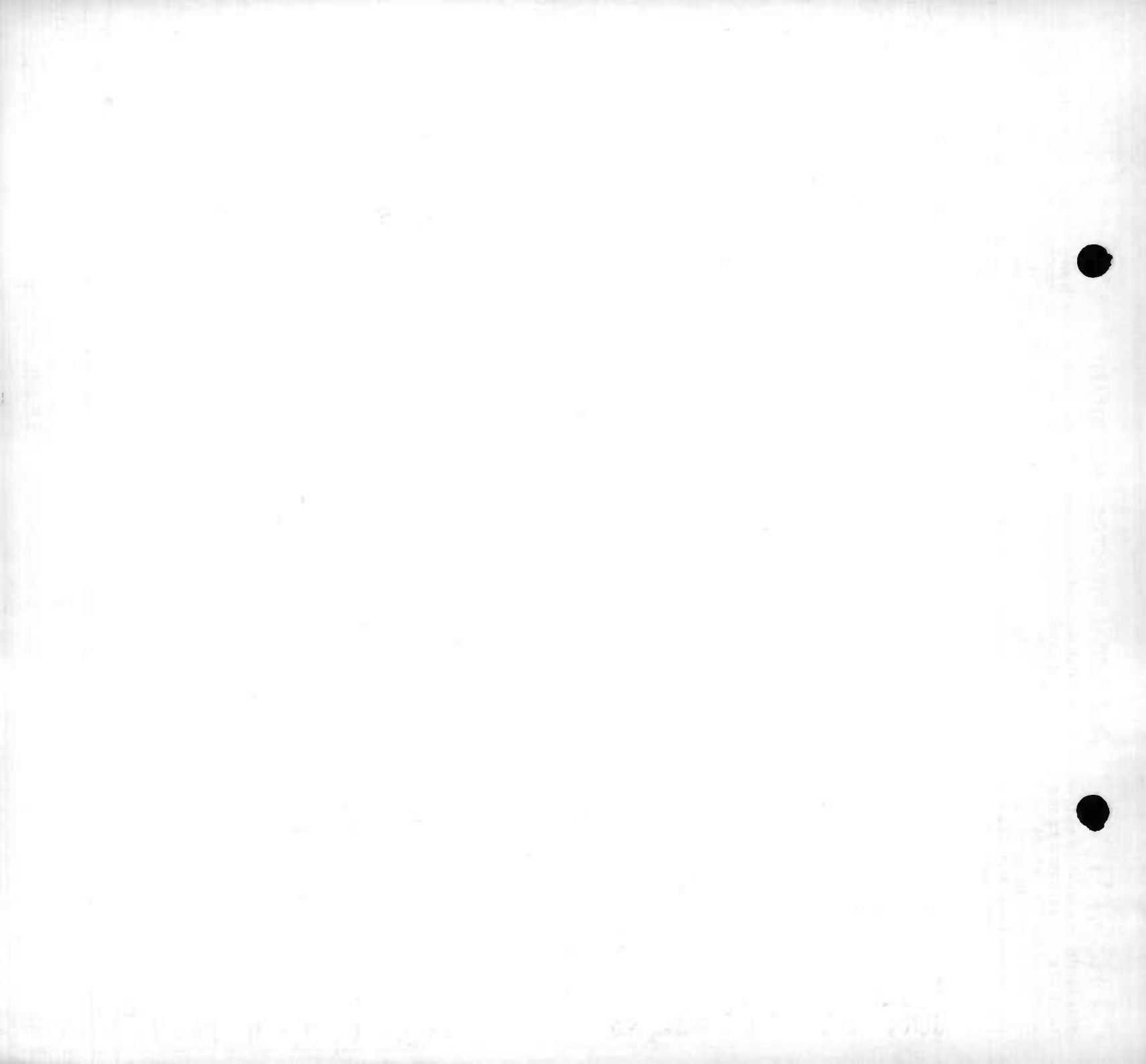
1. NAME OF DECEASED (Type or Print) <b>WILLIAM E. DORSEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>5 31 1970 4:19 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>5-10-1886</b>		10. AGE (In years last birthday) <b>84</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unk.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>	
15. MOTHER'S MAIDEN NAME <b>Unk.</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. Joshua Williams</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		ADDRESS <b>3 Garrett Avenue</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Syphilitic aortic valvulitis</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-3-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Western Star Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 4 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5725	
CERTIFICATE OF DEATH					
BIRTH NO. 4-400 70 5725		1. NAME OF DECEASED (Type or Print) MARY AGNES HALL			
2. DATE AND HOUR OF DEATH 6-1-1970 6:00 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINIA HOSPITAL OF BALTIMORE		A. STATE MARYLAND B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 BALTIMORE.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4309 Penhurst Ave.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1912	9. AGE (In years last birthday) 58yr	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MR. A. HALL.		14. MOTHER'S MAIDEN NAME UNKNOWN (France Germes)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No —		16. SOCIAL SECURITY NO. 218-01-6506		17. INFORMANT MR. RICHARD HALL. ADDRESS BALTIMORE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 398XIV-250.9		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE PULMONARY EDEMA. DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) RHEUMATIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) HYPERTENSION. ASCVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DIABETES MELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (4) (this hospital) attended the deceased from July 1967 to June 1970 that (4) (we) last saw the deceased alive on 5/31/1970 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Jacobson M.B. O.C. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/1/1970	
23C. PHYSICIAN'S NAME (Type) ROBERT J. JACOBSON M.B. O.C. DEGREE		23D. ADDRESS % Sinia Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/70		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS HORTON & Ogett F.H. 1701 LAURENS ST.	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5726

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <p align="center">Herman Harris</p>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <p align="center">1031 Pennsylvania Ave.</p>		3. DATE PRONOUNCED DEAD Month Day Year Hour <p align="center">6 2 70 10:40 a.m.</p>	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY <u>1702</u>	
9. DATE OF BIRTH 12-18-1914		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Halifax Co., N.C.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Thomas Harris, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
15. MOTHER'S MAIDEN NAME Lucinda Alston		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Victoria H. Reed	
19. ADDRESS Littleton		20. ADDRESS P.O. Box 20 N.C.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <p align="center">Arteriosclerotic cardiovascular disease</p>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		

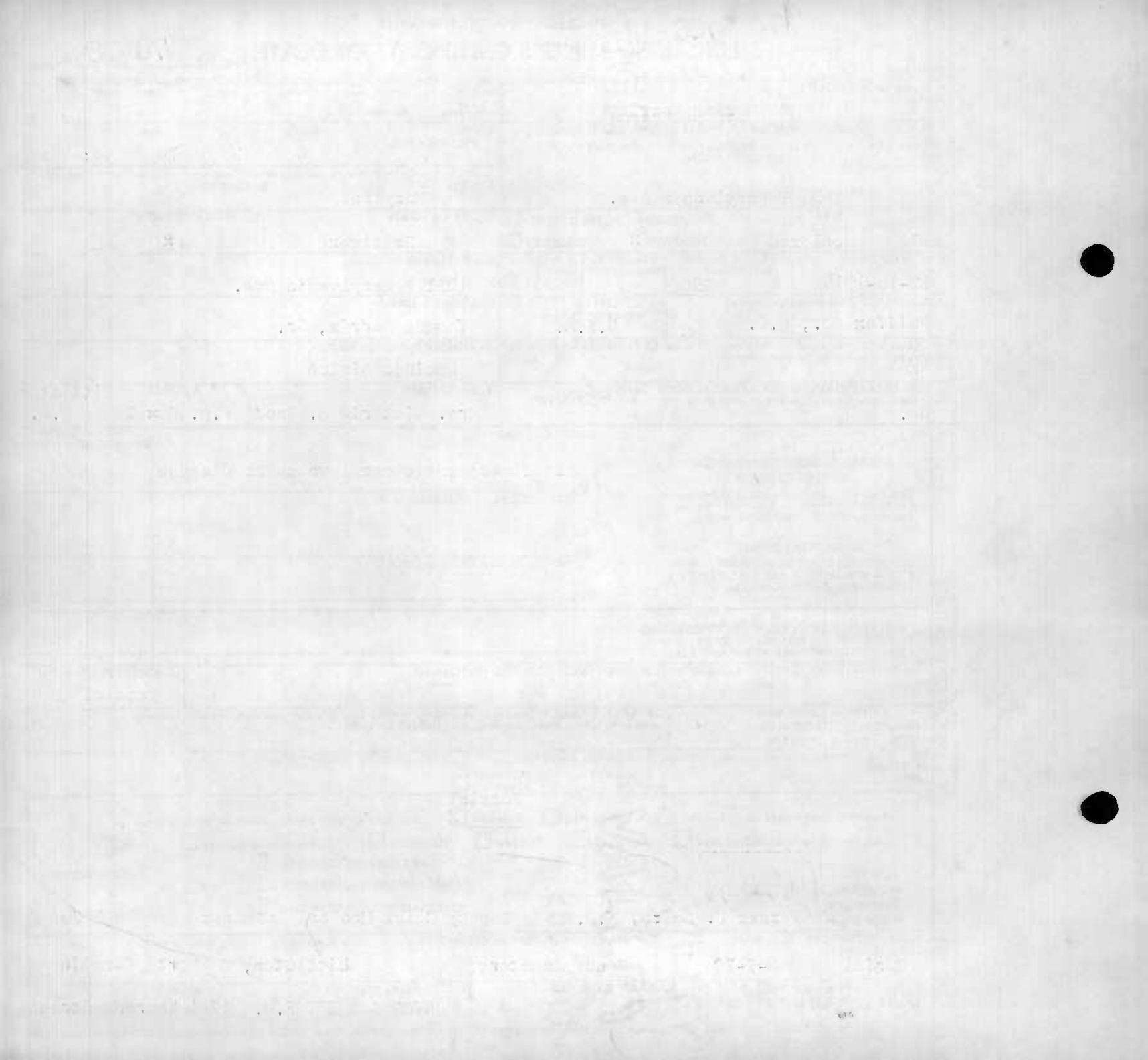
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) partial
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER ☐

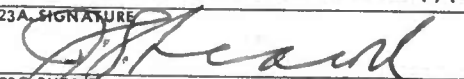
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner ☐ DATE SIGNED 6/2/70

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-7-70	24C. NAME OF CEMETERY or CREMATORY Bonds Cemetery	24D. LOCATION (City, town, or county) (State) Littleton, North Carolina
25A. DATE REC'D BY HEALTH DEPT. JUN 4 1970	25B. NAME OF REGISTRAR Jabab E. [unclear]	25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	25D. ADDRESS 1701 Laurens Street



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
R-240 70 5727		70 5727		70 5727	
BIRTH NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		WILLIAM E. ROSZELL JR.		May 30, 1970 9:30 p.m.	
		William Roszell Jr.			
<b>CERTIFICATE AMENDED</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
39 PROVIDENT HOSPITAL, INC. 1514 DIVISION STREET BALTIMORE, MARYLAND 21217			A. STATE Maryland B. COUNTY 1402		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Retired/Sunpapers					12-25-10 59
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)
Baltimore, Maryland			U.S.A.		59
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William E Roszell			Othella Glaeser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			212-09-9682		Mrs Mary T Roszell
					ADDRESS
					Same
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>PULMONARY INSUFFICIENCY</u> 48 HOURS DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PROGRESSIVE PNEUMOTHORAX</u> 7 DAYS DUE TO, OR AS A CONSEQUENCE OF: (C) <u>EMPHYSEMA</u> YEARS II <u>CHRONIC ALCOHOLISM</u> YEARS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 24, 1970 to May 30, 1970 and that (I) (we) last saw the deceased alive on May 30, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
 Dr. F. Leacock M.D.				6-1-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. F. Leacock M.D.				1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/3/70		Gardens Of Faith	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 5 1970		Robert E. Leacock		Leonard J. Ruck Inc. Baltimore, Maryland	
				ADDRESS	

VS 153

6-4-79  
M.A.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**S-451** **70 5728** **CERTIFICATE OF DEATH** **REG. NO. 70 5728**

**BIRTH NO.** **1. NAME OF DECEASED** (Virginia Carroll Schillinberg) **DATE AND HOUR OF DEATH** June 3, 1970 8<sup>10</sup> P.M.

(Type or Print) **Schillinberg, Mrs. Virginia H.**

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD** **4. USUAL RESIDENCE** (Where deceased lived, if institution; residence before admission)

**Full Name of Hospital or Institution** (If not in hospital or institution, give street address or location) **Maryland**

**Keswick** **5. CITY OR TOWN** **Baltimore** **6. INSIDE CITY LIMITS?** YES ☒ NO ☐

**700 West 40th Street, Baltimore, Md.** **7. STREET AND NUMBER** **3100 St. Paul Street**

**3502 North Charles Street**

**5. SEX** Female **6. RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ **8. DATE OF BIRTH** May 10, 1893 **9. AGE** (In years last birthday) 77 yrs. **10. A. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Mfg. Rep. - Union Canvas Goods Co. **10B. KIND OF BUSINESS OR INDUSTRY** Sold canvas-tarpaulin-coal bag type prod. **11. BIRTHPLACE** (State or foreign country) Baltimore City **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME** Carroll Joseph C. Hands **14. MOTHER'S MAIDEN NAME** Maude D. White

**15. Was Deceased Ever in U. S. Armed Forces?** (Yes, no or unknown) No **16. SOCIAL SECURITY NO.** 216-12-8950 **17. INFORMANT** Keswick Medical Records, 700 W. 40th St. **ADDRESS**

**18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** **CAUSE OF DEATH** **APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH**

**(A) IMMEDIATE CAUSE** Cerebral thrombosis 1 month

**(B) DUE TO, OR AS A CONSEQUENCE OF:** Arteriosclerosis, generalized 5 years

**(C) DUE TO, OR AS A CONSEQUENCE OF:** Carcinoma of breast, treated 5 years

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).**

**19A. DATE OF OPERATION** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY?** (Yes or No) **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (notify medical examiner) **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME OF INJURY** (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

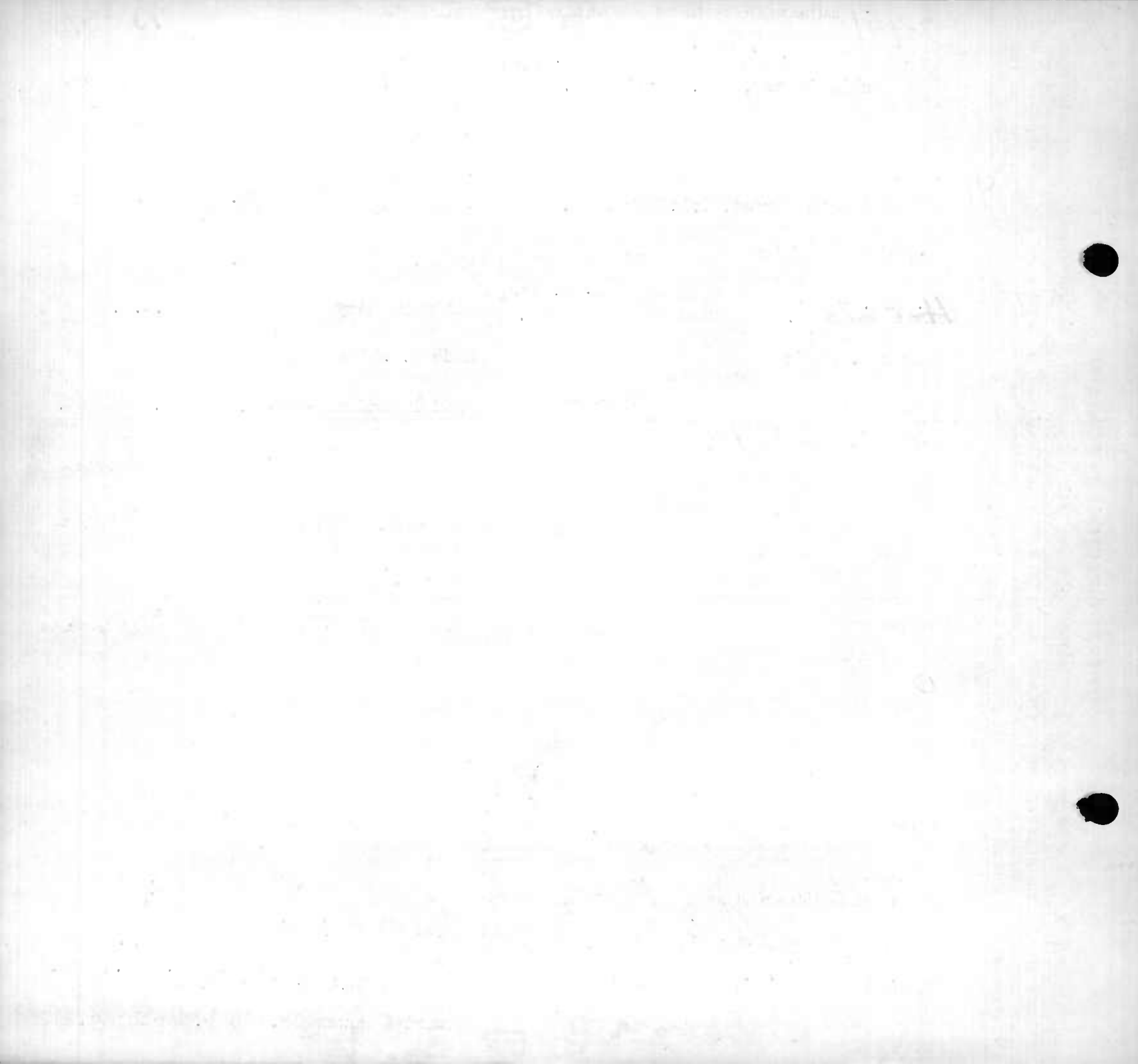
**22. I certify that (this hospital) attended the deceased from** 4/7/70 **19** **to** 6/3/70 **19** **that (we) last saw the deceased alive on** 6/3/70 **19** **and that in (our) opinion death occurred on the date** **and hour and from the causes stated above. (We) (did) (did not) view the body after death.**

**23A. SIGNATURE** **23B. DATE SIGNED** 6/4/70

**23C. PHYSICIAN'S NAME (Type)** W. B. Daniels, Jr. **23D. ADDRESS** Keswick, 700 W. 40th St. Baltimore Md

**24A. BURIAL CREMATION, REMOVAL (Specify)** Burial **24B. DATE** 6/6/70 **24C. NAME OF CEMETERY OR CREMATORY** Lorraine Cemetery **24D. LOCATION** (City, town, or county) (State) Woodlawn, Balto. Co., Md.

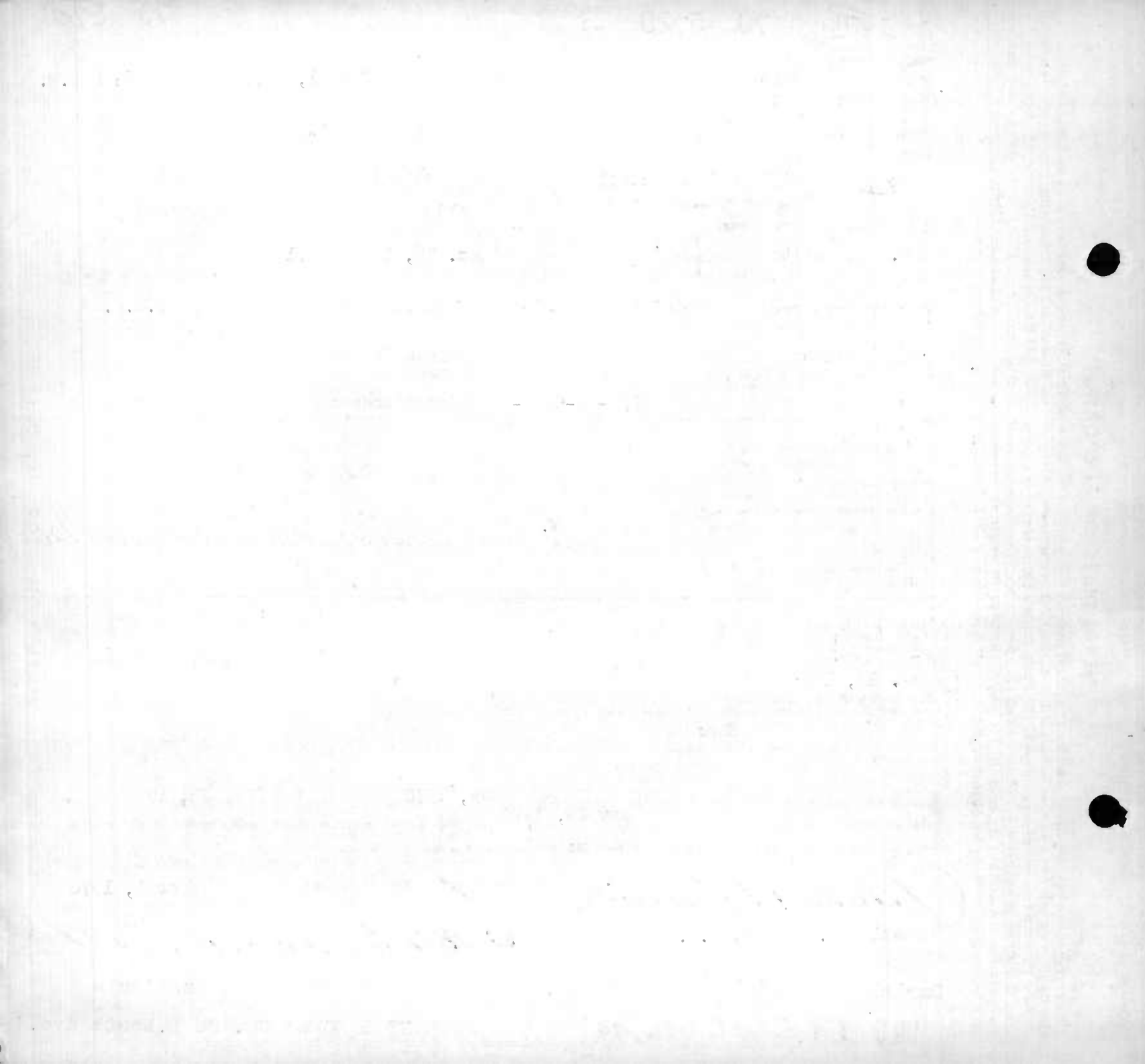
**25. DATE REC'D BY HEALTH DEPT.** JUN 5 1970 **25B. NAME OF REGISTRAR** **25C. FUNERAL DIRECTOR** Stewart & Mowen Co. **ADDRESS** 108 W. North Av. 21201



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Sister Regina Hannon (Ann Rdgina)				June 1, 1970				8:30 P.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY							
94 Villa Saint Michael				Maryland City				2841			
4000 Forest Hill Road				C. CITY OR TOWN D. INSIDE CITY LIMITS?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER				4000 Forest Hill Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days					
F.	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 25, 1898	71							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Teacher (retired)				Sister of Charity				Philadelphia			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Daniel Hannon				Hannah Massey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				061-42-0086-T				Sister Andrea same address			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Carcinomatosis			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				Cadenocarcinoma of uterus Nov 10 1969			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
Nov. 10, 1969								No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
None											
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from May, 1970 to May 26, 1970				19				19			
that (I) (we) last saw the deceased alive on May 26, 1970				19				and that In (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Damian P. Alagia, M.D.				June 1, 1970							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Damian P. Alagia, M.D.				3341 E. ...							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				6/4/70				Villa St. Michael on grounds Seton Institute			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUN 5 1970				Robt. E. ...				STEWART & MOWEN CO. 108 W. North Ave. 1			



## CERTIFICATE OF DEATH

REG. NO.

70 5730

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY M. KRIEGER

2. DATE AND HOUR OF DEATH

6/3/70

3<sup>20</sup> A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7354 Geis Avenue 21219

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-26-87

9. AGE (In years  
last birthday)

82

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Prieber (Dec)

14. MOTHER'S MAIDEN NAME

Anna Bussey

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
217-01-3577D

17. INFORMANT

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Cardiogenic Shock

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 hours

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:(B) Acute myocardial infarction  
DUE TO, OR AS A CONSEQUENCE OF:

6 hours

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Hypertension &amp; Chronic Congestive Heart Failure

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/2 19 70 to 6/3 19 70  
that (I) (we) last saw the deceased alive on 6/3 19 70 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James R. Fonk M.D.

Attending ☐  
Phys.Med. Director ☐Staff ☒  
Phys.

23B. DATE SIGNED

6/3/70

23C. PHYSICIAN'S  
NAME (Type)

JAMES R. FONK M.D.

23D. ADDRESS

BALTO. CITY HOSP. 21224  
4940 - EASTERN AVE. BALTO. MD.24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

June 6-70 Bel Air Memorial Gardens

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

Bel Air

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1970

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

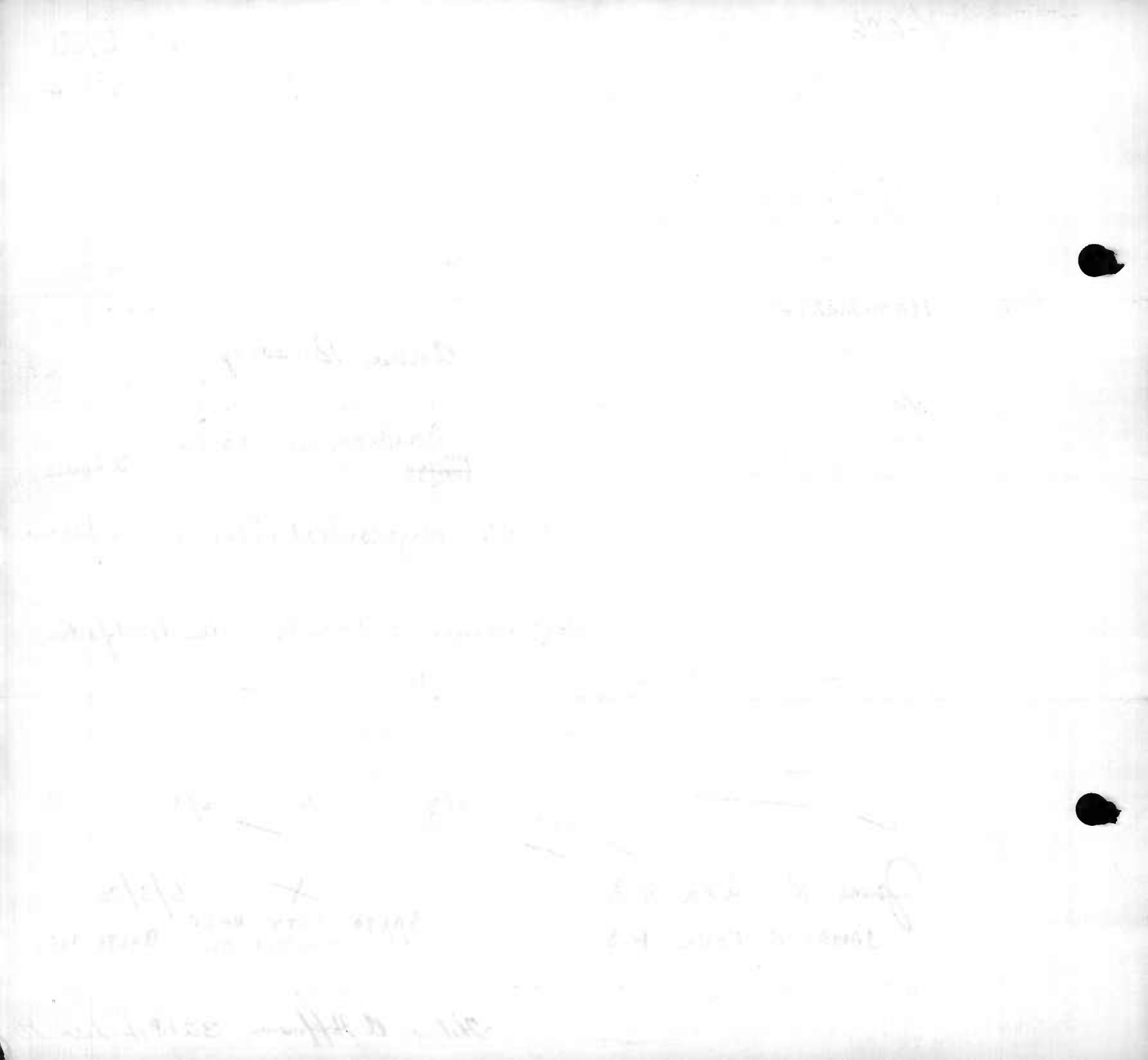
Helma A. Hoffmann

ADDRESS

3218 Hudson St.

FUNERAL DIRECTOR: IMPORTANT

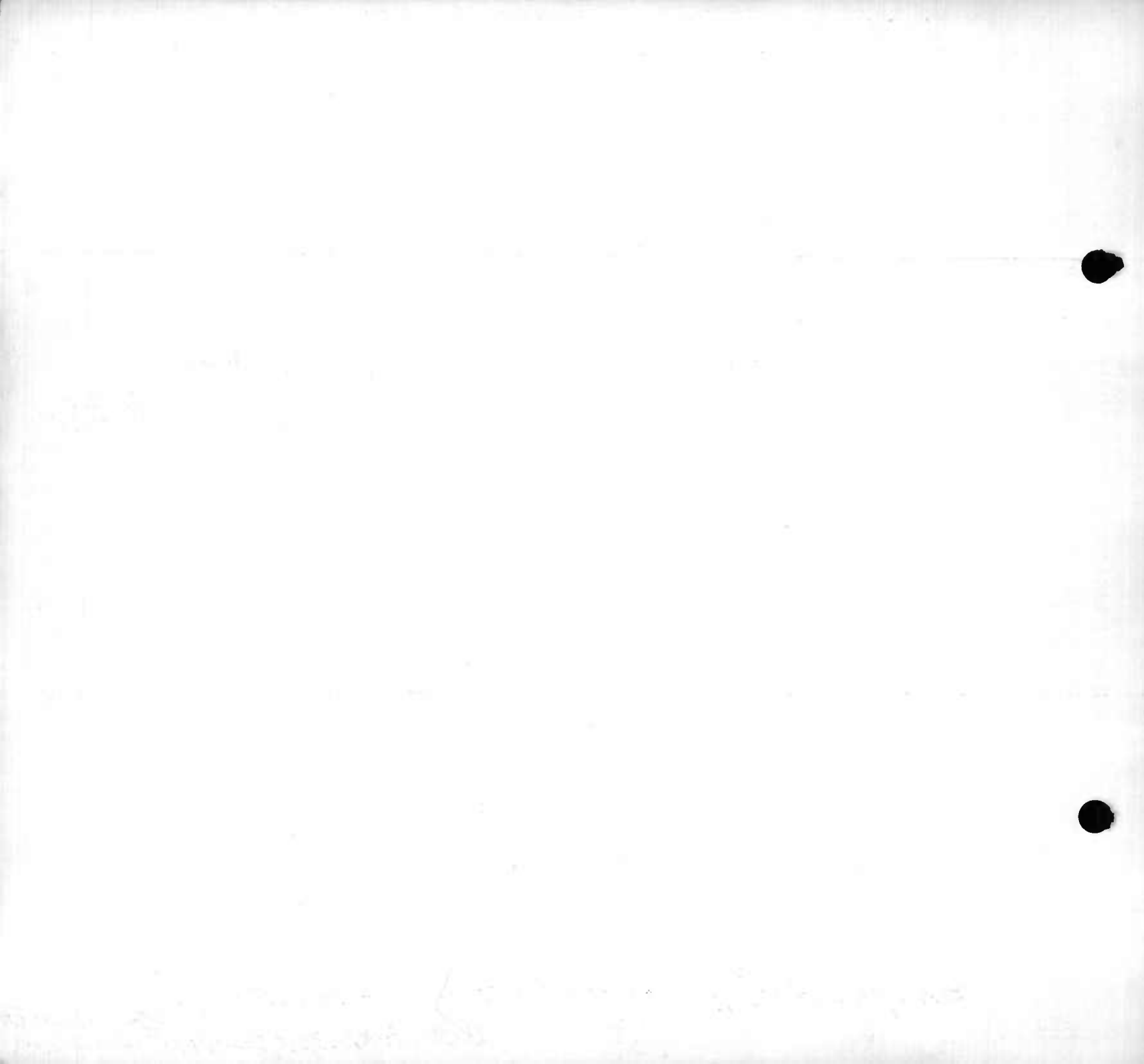
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

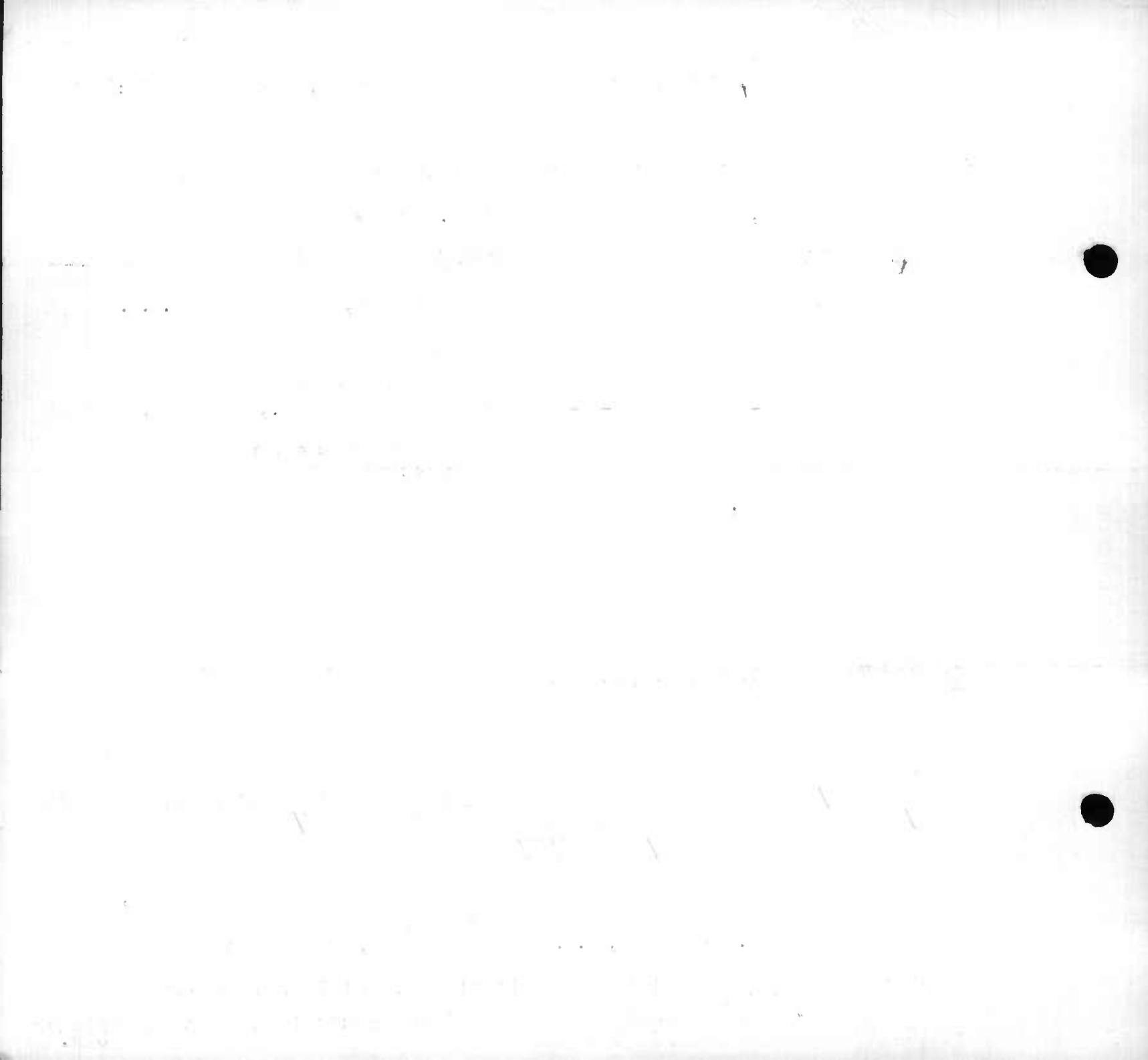
G-560		70 5731		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5731	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ERNEST CHARLES GAINER</b>			
2. DATE AND HOUR OF DEATH <b>6/2/70 4:15 PM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>43 South Baltimore General Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2505</b>				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>			
6. DATE OF BIRTH <b>12-4-13</b>				7. AGE (In years last birthday) <b>56</b>			
8. CITY OR TOWN <b>BALTIMORE</b>				9. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10. STREET AND NUMBER <b>3607 FAIRHAVEN AVE 21226</b>				11. BIRTHPLACE (State or foreign country) <b>W. VA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ARLIE GAINER</b>			
14. MOTHER'S MAIDEN NAME <b>LENA HARRER</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>HAZEL - WIFE, 3607 FAIRHAVEN AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I RUPTURED MYOCARDIUM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b> <b>Coronary Arteriosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 15 1970</b> to <b>JUNE 2 1970</b> that (I) (we) last saw the deceased alive on <b>JUNE 2 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>6/3/70</b>		23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
23D. ADDRESS <b>[Address]</b>				23E. ADDRESS <b>[Address]</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL - REMOVAL</b>		24B. DATE <b>JUNE 3, 70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>WEAVERS CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>HARRISBURG, VA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUNE 10 1970</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b>		25D. ADDRESS <b>[Address]</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

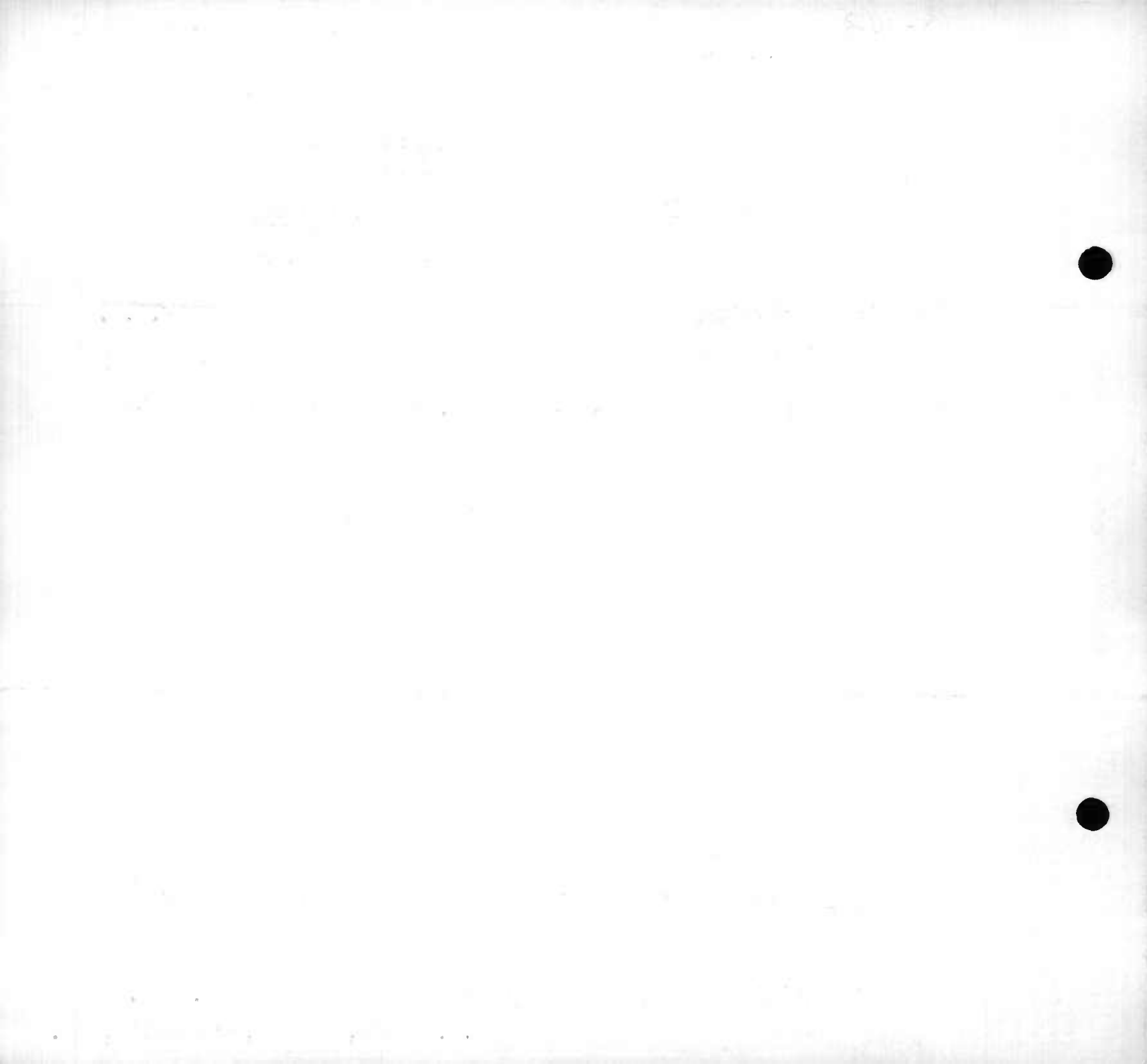
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5732</span>	
CERTIFICATE OF DEATH					
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">S-542</span>		<b>70 5732</b>		<b>DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>June 2, 1970</span> <span>10:20 A.M.</span> </div>	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>SCHMELZ, Frederick Richard</b>			<b>2. DATE AND HOUR OF DEATH</b> June 2, 1970 10:20 A.M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">23</span> Veterans Administration Hospital                      3900 Loch Raven Boulevard                      Baltimore, Maryland 21218                 </div> <div style="width: 50%;"> <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)                      A. STATE <b>Maryland</b>                      B. COUNTY <span style="font-size: 1.5em;">1903</span> </div> </div>			<b>5. CITY OR TOWN</b> Baltimore		
<b>6. STREET AND NUMBER</b> 330 S. Gilmore Street			<b>7. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>8. SEX</b> Male		<b>9. RACE</b> White		<b>10. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>11. DATE OF BIRTH</b> 12/25/95		<b>12. AGE</b> (In years last birthday) 74		<b>13. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>14. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Bar Tender			<b>15. BIRTHPLACE</b> (State or foreign country) Brooklyn, New York		
<b>16. FATHER'S NAME</b> John Schmeltz			<b>17. MOTHER'S MAIDEN NAME</b> Mary Mench		
<b>18. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/25/18 - 7/10/19		<b>19. SOCIAL SECURITY NO.</b> 579-09-8555		<b>20. INFORMANT</b> VA Hospital Records 3900 Loch Raven Blvd., Baltimore, Md 21218	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>Metastatic pancreatic carcinoma</b>  <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF:	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19A. DATE OF OPERATION</b> 5/25/70		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> Intestinal obstruction via CA		<b>20A. AUTOPSY?</b> (Yes or No) YES	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from May 14th 1970 to June 2nd 1970 that (I) (we) last saw the deceased alive on June 2nd 1970 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> June 3, 1970	
<b>23C. PHYSICIAN'S NAME</b> (Type) MICHAEL B. MARCHILDON, M.D.				<b>23D. ADDRESS</b> 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 6/5/70		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Baltimore National Cem.	
<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Maryland		<b>25A. DATE REC'D BY HEALTH DEPT.</b> JUN 5 1970			
<b>25B. NAME OF REGISTRAR</b> Robert E. Baker, M.D.		<b>25C. FUNERAL DIRECTOR</b> Walters Funeral Home Pratt & Sticker			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

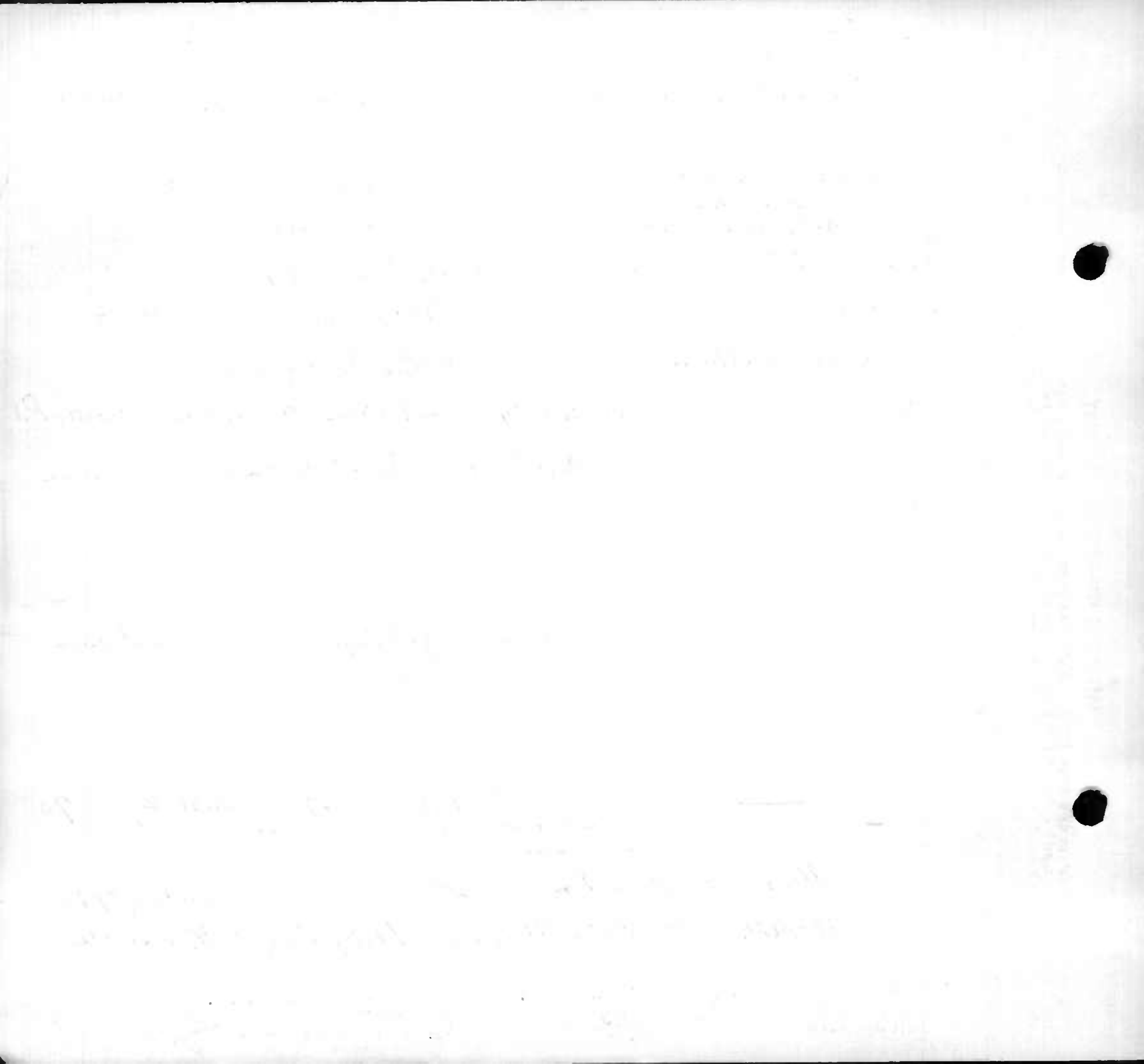
B-143		BALTIMORE CITY HEALTH DEPARTMENT		70 5733	
BIRTH NO.		70 5733		X REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Baublitz James L.</i>			2. DATE AND HOUR OF DEATH <i>6/2/70 9:20 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 UNIVERSITY of MD Hosp.</i>			C. CITY OR TOWN <i>Sykesville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>Route 4 - Box 335</i>		
5. SEX <i>M</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/28/96</i>	9. AGE (in years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Construction worker</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Daniel Baublitz</i>			14. MOTHER'S MAIDEN NAME <i>Nettie Jennette Darby</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1 WW 1 (</i>		16. SOCIAL SECURITY NO. <i>217-09-3483</i>	17. INFORMANT ADDRESS <i>Mrs. Lydia Kidd Same As #4</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Carcinoma of lung</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>for advanced with</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized deterioration</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Generalized arteriosclerosis</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. Shapiro M.D.</i>			23B. DATE SIGNED <i>6/2/70</i>		
23C. PHYSICIAN'S NAME (Type) <i>E. Shapiro M.D.</i>			23D. ADDRESS <i>Carroll Co., Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>Kriders Cemetery</i>	
24D. LOCATION <i>Carroll Co., Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Bailey, R.G.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>C.M. Waltz, Box 241, Sykesville, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

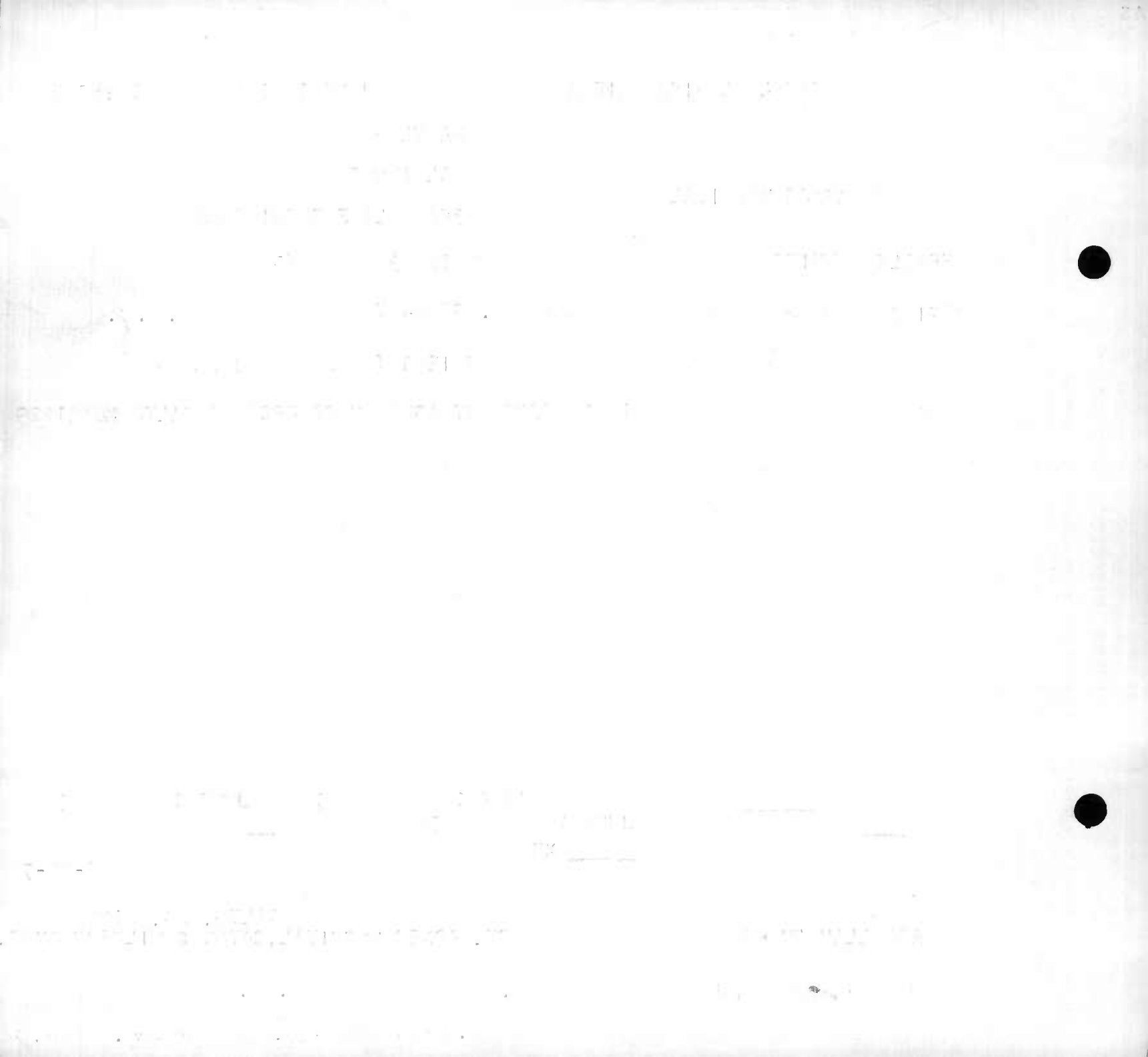
T-656 70 5734		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5734	
1. NAME OF DECEASED (Type or Print) <b>LILLIE V. TURNER</b>			2. DATE AND HOUR OF DEATH <b>JUNE 2, 1970   2:40 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ASHBURTON HOUSE</b> <b>90 3520 HILTON ROAD</b> <b>BALTIMORE MD.</b>			A. STATE <b>Md.</b> 8. COUNTY <b>2834</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>5028 West Hills Rd</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1882</b>	9. AGE (in years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jesse Cullum</b>		14. MOTHER'S MAIDEN NAME <b>Martha Thompson</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-01-0754</b>		17. INFORMANT <b>Ashburton House Nursing Home</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>chronic pyelonephritis</b>				<b>unknown</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1967</b> to <b>June 2, 1970</b> that (I) (we) last saw the deceased alive on <b>June 2, 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham B. Hurwitz MD</b>				23B. DATE SIGNED <b>June 2, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ, MD</b>				23D. ADDRESS <b>7501 Liberty Road Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 5, 1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cem.</b>	
24D. LOCATION <b>Glenn Burnie, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>G. J. Suvon-Salunola</b>			
25D. ADDRESS					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-240 70 5735		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5735	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SAGEL, LOUISA FRIEDA		JUNE 1, 1970 11:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY	
40 ST AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3502 OLD FREDERICK RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 12 03	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED Machine-Operator		Pittsburg Plate Co.		GERMANY	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Ernest Trepte			
14. MOTHER'S MAIDEN NAME FRIEDA ( Ida ) Scheinpflug		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 218 22 5575		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS BALTO MD 21229			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Myocardial infarction A. S. C. V. D.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 1 1970 to JUNE 1 1970 that (I) (we) last saw the deceased alive on JUNE 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Shams, M.D.		23B. DATE SIGNED 06-02-70		23C. PHYSICIAN'S NAME (Type) ABDOLLAH SHAMS	
23D. ADDRESS BALTO. MD. 21229 ST. AGNES HOSPITAL, CATON & WILKENS AVES.		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 4, 1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		24E. DEGREE			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR Robert E. Schab		25C. FUNERAL DIRECTOR G. Truman Schwab	
25D. ADDRESS 3512 Frederick Ave.		25E. BALTO. MD.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-160 70 5736		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5736	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LABARRE, WILLIAM D</u>		2. DATE AND HOUR OF DEATH <u>June 2, 1970</u> <u>9:55 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		E. STREET AND NUMBER <u>22 S. WALKER AVE.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-03</u>	9. AGE (in years last birthday) <u>66</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIRE REPAIR</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Clarke Labarre</u>		14. MOTHER'S MAIDEN NAME <u>DAVIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>196-18-6692</u>		17. INFORMANT <u>EMMA LABARRE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.1 I</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>5:28</u> <u>19 70</u> to <u>6:2</u> <u>19 70</u>		that (I) <del>was</del> last saw the deceased alive on <u>6:2</u> <u>19 70</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.			
23A. SIGNATURE <u>Sam B. Kerr M.B.C.B.</u>		23B. DATE SIGNED <u>6-2-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>IAIN C. KERR M.B.C.B.</u>		23D. ADDRESS <u>BON SECOURS HOSPITAL, 2025 W. PAYETTE ST BALTO #23</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>6/6/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>DAK LAWN</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert A. [illegible]</u>		25C. FUNERAL DIRECTOR <u>Corrigan Funeral Home 300 [illegible]</u>	

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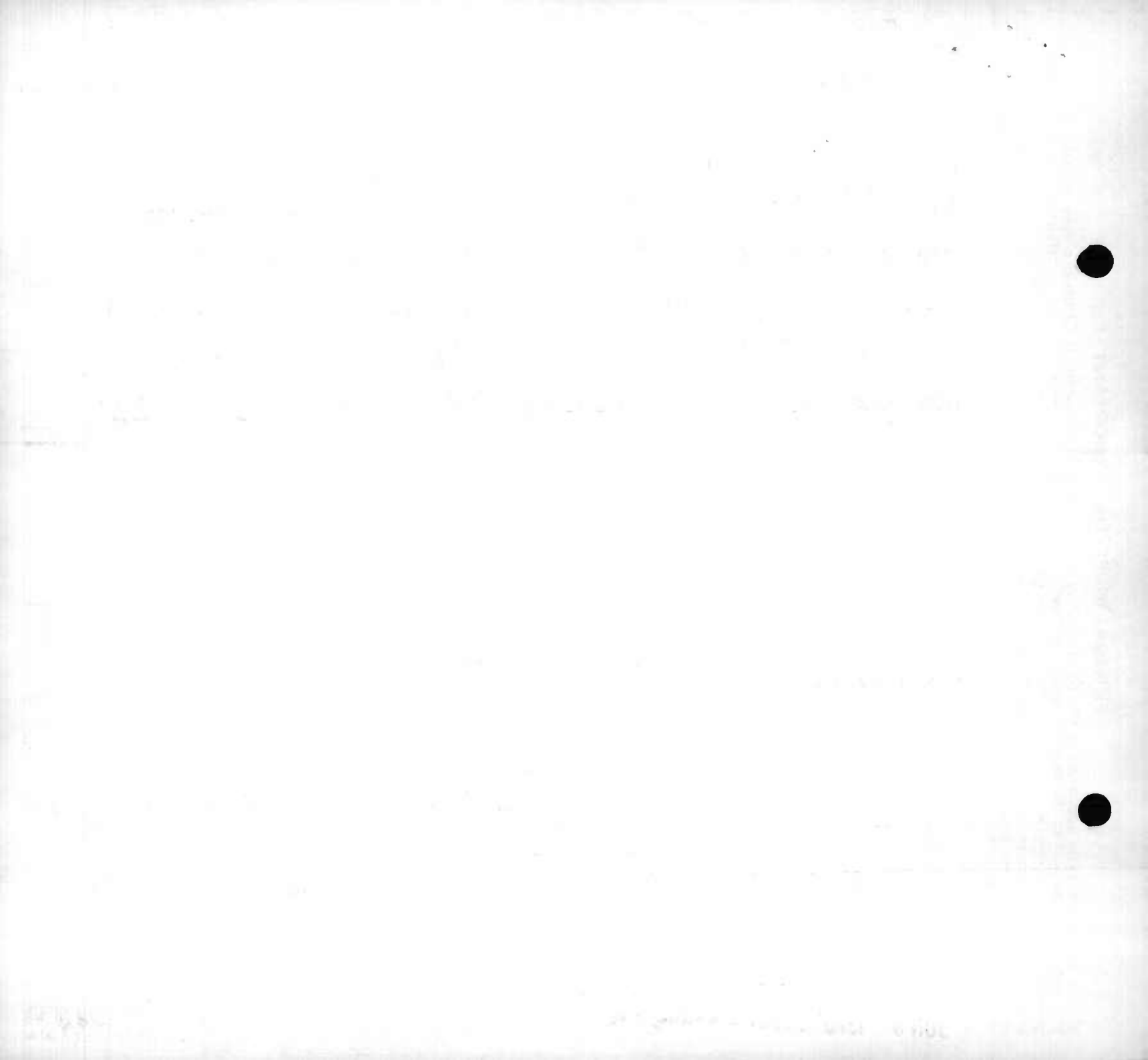
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5737
C-500 70 5737 CERTIFICATE OF DEATH				REG. NO. 70 5737
1. NAME OF DECEASED (Type or Print) <b>CANN, CARLTON D.</b>		2. DATE AND HOUR OF DEATH <b>JUNE 2 1970 8:20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> 8. COUNTY <b>2841</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>33 RD 6 CALVERT STS. BALTO MD</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>4401 PENHURST Ave. 21215</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-02-90</b>	9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water Proofing Bus.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>E. BERTRAM B. CANN</b>		14. MOTHER'S MAIDEN NAME <b>ALICIE McBees</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-03-7092</b>		17. INFORMANT <b>HEAD NURSE HALLS-3-11</b>
18. <b>152.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>SECONDARY SJAUNDICE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CARCINOMA OF DUODENUM</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>U.M.M.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>HE</b>				
19A. DATE OF OPERATION <b>5/21/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OBSTRUCTIVE JAUNDICE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> 19 <b>70</b> to <b>6/21</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/21</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Ashwin-Menta</b>				23B. DATE SIGNED <b>6/21/70</b>
23C. PHYSICIAN'S NAME (Type) <b>ASHWIN. MENTA</b>		23D. ADDRESS <b>MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/5/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Vally</b>		
		25C. FUNERAL DIRECTOR <b>Loring Byers</b>		
		ADDRESS <b>8728 Liberty Rd. Randallstown</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>P-430 70 5738</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>70 5738</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="border: 1px solid black; padding: 2px;">70 5738</span>	
BIRTH NO. <span style="border: 1px solid black; padding: 2px;">P-430</span> 1. NAME OF DECEASED (Type or Print) <span style="border: 1px solid black; padding: 2px;">Plitt, Paul B.</span>		2. DATE AND HOUR OF DEATH <span style="border: 1px solid black; padding: 2px;">June 1 - 1970 10:35 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <span style="border: 1px solid black; padding: 2px;">8-24-70</span> ADDRESS OR LOCATION <span style="border: 1px solid black; padding: 2px;">91 Keswick 700 W 40th St</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="border: 1px solid black; padding: 2px;">Maryland</span> B. COUNTY <span style="border: 1px solid black; padding: 2px;">1307</span> C. CITY OR TOWN <span style="border: 1px solid black; padding: 2px;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="border: 1px solid black; padding: 2px;">700 W - 40th St</span>	
5. SEX <span style="border: 1px solid black; padding: 2px;">M</span>	6. RACE <span style="border: 1px solid black; padding: 2px;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="border: 1px solid black; padding: 2px;">9-30-1889</span>
9. AGE (In years last birthday) <span style="border: 1px solid black; padding: 2px;">81</span>		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="border: 1px solid black; padding: 2px;">House painter</span>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <span style="border: 1px solid black; padding: 2px;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="border: 1px solid black; padding: 2px;">USA</span>	
13. FATHER'S NAME <span style="border: 1px solid black; padding: 2px;">Charles Plitt</span>		14. MOTHER'S MAIDEN NAME <span style="border: 1px solid black; padding: 2px;">Elizabeth Miller</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="border: 1px solid black; padding: 2px;">yes</span>		16. SOCIAL SECURITY NO. <span style="border: 1px solid black; padding: 2px;">214-14-4660</span>	
17. INFORMANT <span style="border: 1px solid black; padding: 2px;">Keswick Records</span>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="border: 1px solid black; padding: 2px;">Cerebral hemorrhage</span> (B) <span style="border: 1px solid black; padding: 2px;">Arteriosclerotic CVA</span> (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="border: 1px solid black; padding: 2px;">1 wk</span> <span style="border: 1px solid black; padding: 2px;">2 yrs.</span>			
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <span style="border: 1px solid black; padding: 2px;">6-4-70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="border: 1px solid black; padding: 2px;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="border: 1px solid black; padding: 2px;">AUG. 1969</span> to <span style="border: 1px solid black; padding: 2px;">1 June 1970</span> that (I) (we) last saw the deceased alive on <span style="border: 1px solid black; padding: 2px;">1 June 1970</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="border: 1px solid black; padding: 2px;">Harold P. Biehl</span>		23B. DATE SIGNED <span style="border: 1px solid black; padding: 2px;">2 June 70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="border: 1px solid black; padding: 2px;">Harold P. Biehl, M.D.</span>		23D. ADDRESS <span style="border: 1px solid black; padding: 2px;">700 W. 40th Street 21211</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="border: 1px solid black; padding: 2px;">Burial</span>		24B. DATE <span style="border: 1px solid black; padding: 2px;">6-4-70</span>	
24C. NAME of CEMETERY or CREMATORY <span style="border: 1px solid black; padding: 2px;">Immanuel Lutheran Cemetery</span>		24D. LOCATION (City, town, or county) <span style="border: 1px solid black; padding: 2px;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="border: 1px solid black; padding: 2px;">JUN 5 1970</span>		25B. NAME OF REGISTRAR <span style="border: 1px solid black; padding: 2px;">Robert E. Taylor, R.D.</span>	
25C. FUNERAL DIRECTOR <span style="border: 1px solid black; padding: 2px;">John C. Miller Inc-6415 Belair Rd.</span>		ADDRESS <span style="border: 1px solid black; padding: 2px;">-21206</span>	

Letter Keswick Home for Incurables  
8-24-70 M. H.

No Transcripts  
ntd.

1

C-41670 5739

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5739

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EDNA CALVERT

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital D.O.A.

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

9-6-1912

10. AGE (In years  
last birthday)

57

11. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Entertainer

14B. KIND OF BUSINESS OR INDUSTRY

TED FRIDERIDA LE BOSSIER  
NEUR16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

218-18-1106

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

5

28

70

4:22 p.m.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

May

28

1970

4:22 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

BALTO.

2743

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

3402 Southern Ave. Balto. 21204

13. FATHER'S NAME

Otto W. Hurley

15. MOTHER'S MAIDEN NAME

Unknown

18. INFORMANT

ADDRESS

Coleman C. Calvert 3402 Southern Ave. 3414

19. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Apoplectic intracerebral hemorrhage  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive and arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Chronic renal failure; pulmonary emphysema

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/29/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6-1-1970

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county) (State)

Parkville Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1970 Robert E. Hurler, R.D.

Lassahn Funeral Home 7401 Belair Road

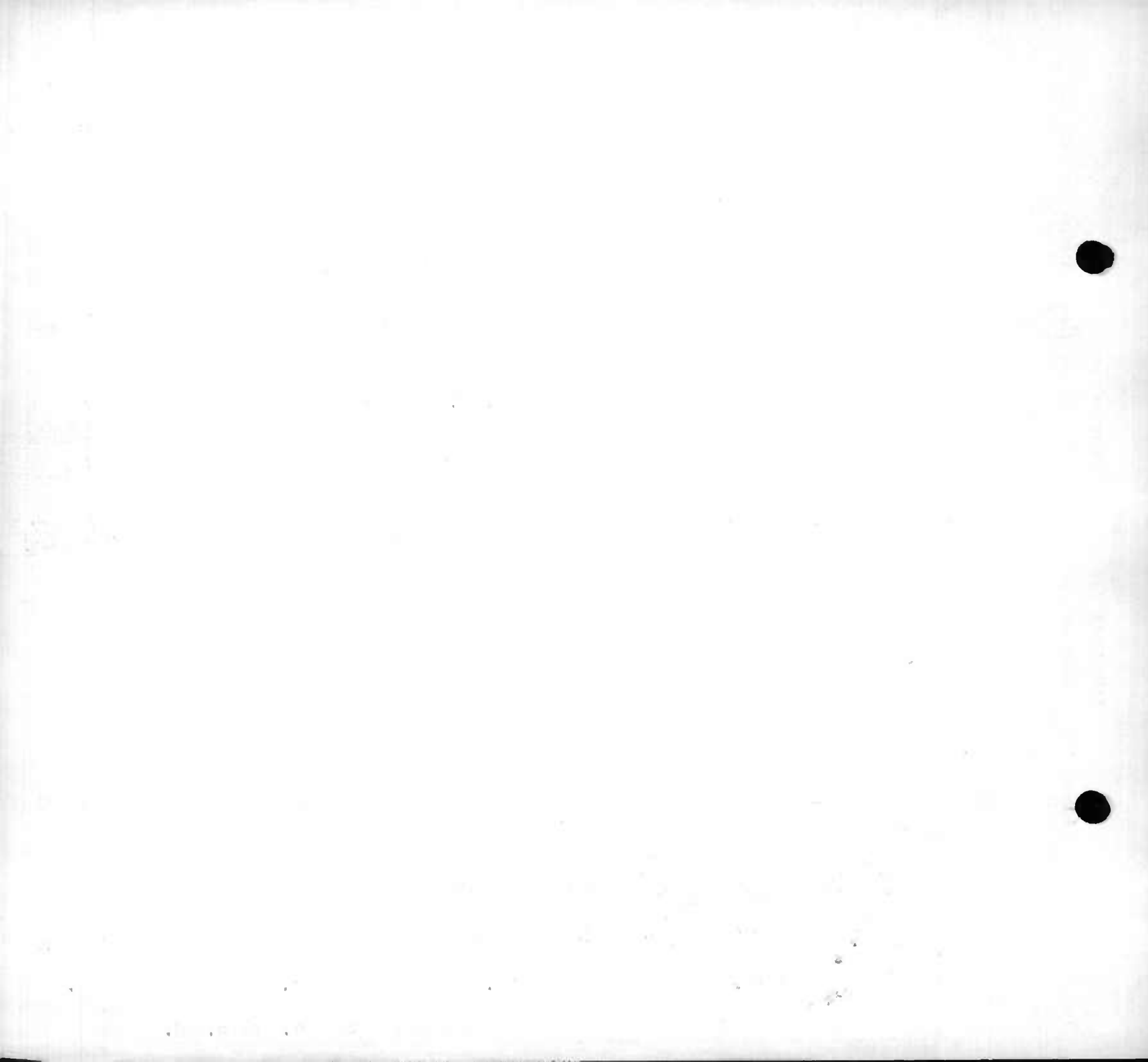




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

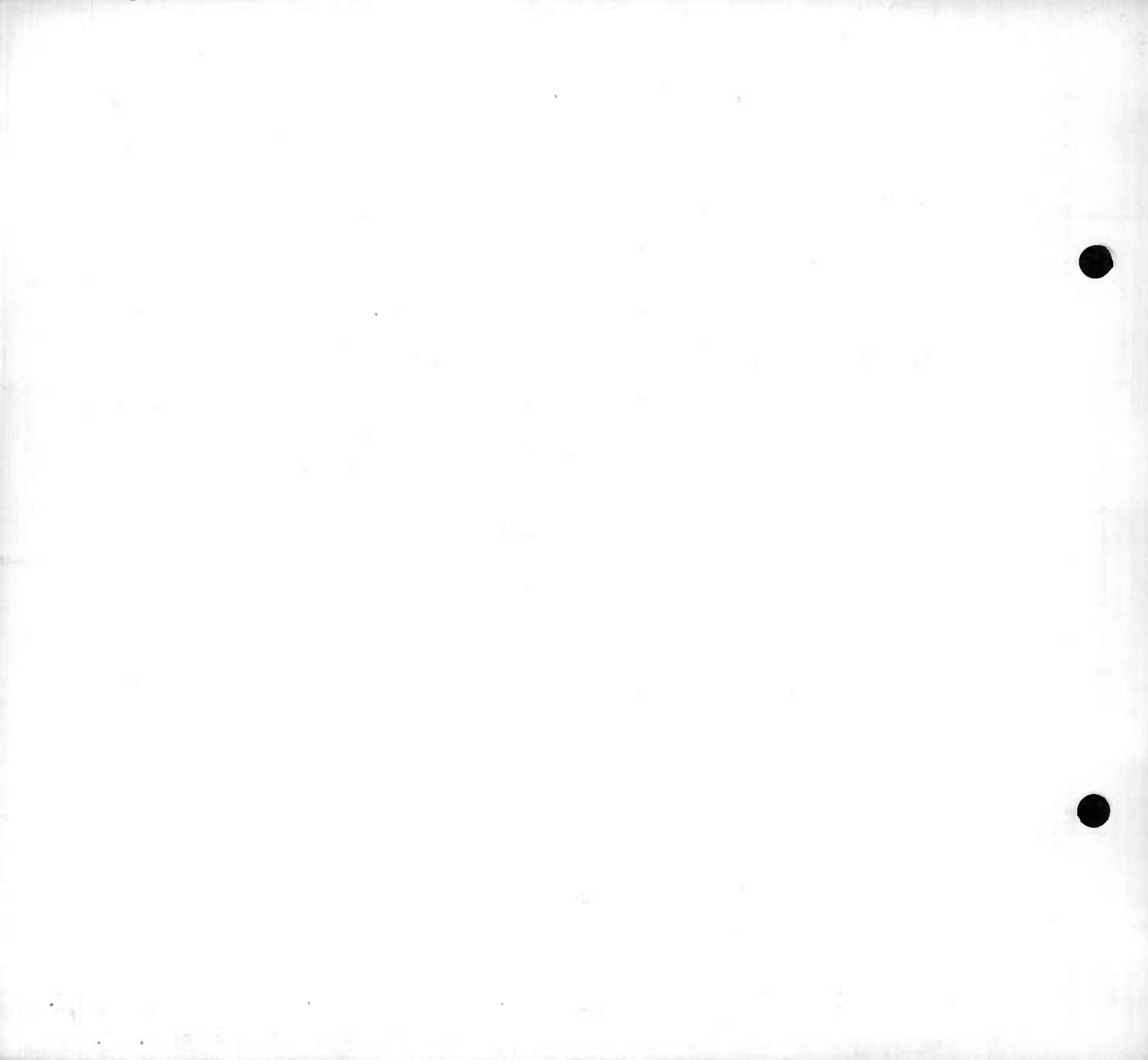
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5740	
L-200 70 5740		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Agnes H. Lewis</u>		2. DATE AND HOUR OF DEATH <u>6-3-70</u> <u>200 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing + Convalescent Center</u> <u>1213 Light Street</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>3508 Frankford Avenue</u> B. COUNTY <u>2744</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1213 Light Street</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-76</u>	9. AGE (in years last birthday) <u>93</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Samuel D. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kehoe</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-54-6332</u>		17. INFORMANT <u>Mrs. Frances E Kline</u> ADDRESS <u>3508 Frankford Ave</u>	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>several months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-2-1970</u> to <u>6-3-1970</u> that (I) (we) last saw the deceased alive on <u>6-2-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook M.D.</u>		23B. DATE SIGNED <u>6-3-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook M.D.</u>		23D. ADDRESS <u>2431 Maryland Ave. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-6-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION <u>Balto.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

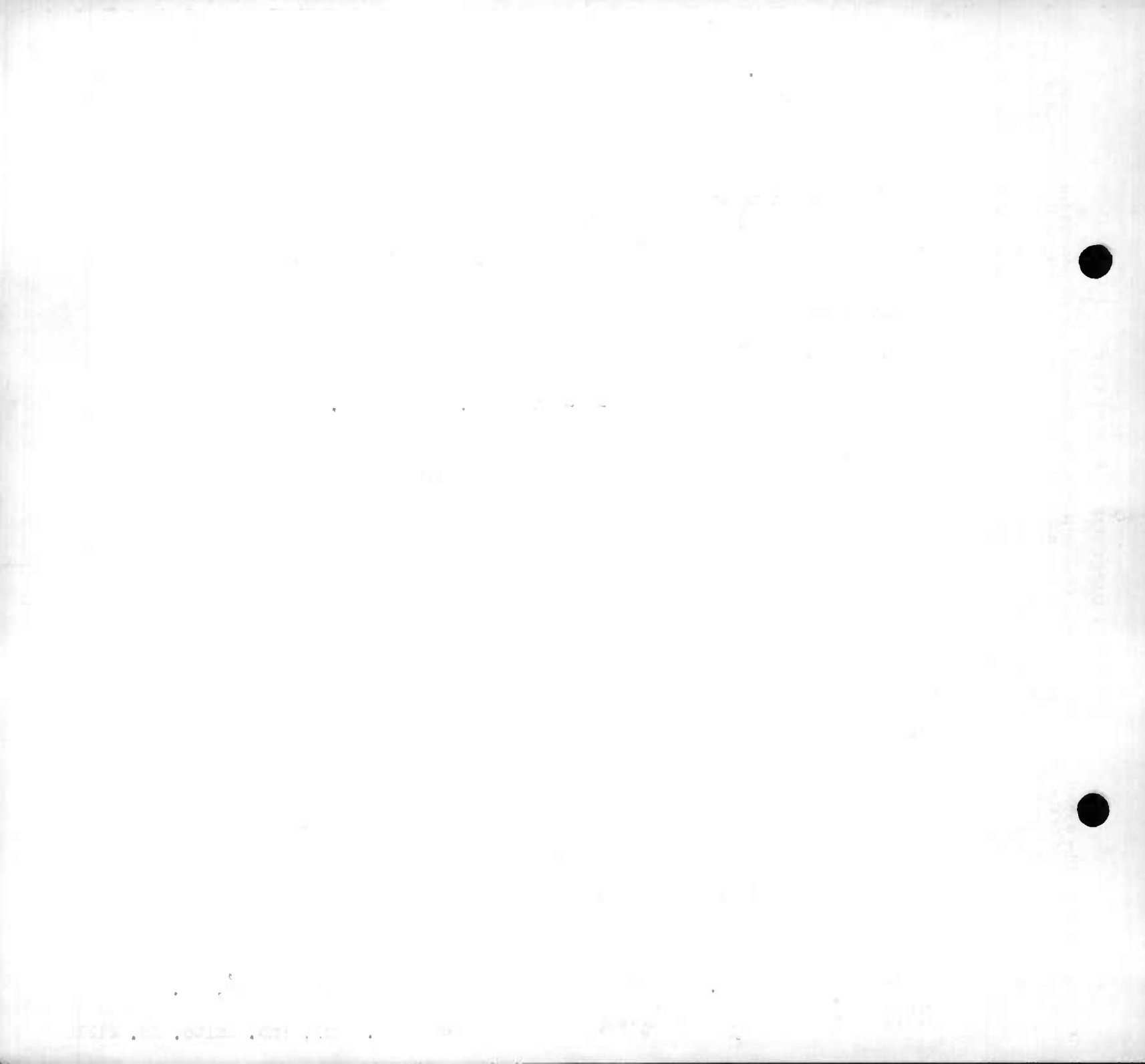
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5741</u>	
S-520 70 5741		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SHANK, ANDREW B.</u>		2. DATE AND HOUR OF DEATH <u>6-2-70 3:57 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTO, MARYLAND</u> B. COUNTY <u>BELLEVUE</u> C. CITY OR TOWN <u>BALTO, MARYLAND</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4413 BELLEVUE AVE - 2841</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-13-85</u>	9. AGE (In years last birthday) <u>85</u>	10. UNDER 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Fruit Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>		11. BIRTHPLACE (State or foreign country) <u>XXX Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JESSE SHANK</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>MEAN 216-039409A</u>		17. INFORMANT <u>ELLA SHANK (WIFE)</u> ADDRESS <u>SAME</u>			
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC HEART DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARDIAC ARREST</u> <u>CHH</u> <u>ASHA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-26-70</u> 19 <u>70</u> to <u>6-2-</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-2-</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Julio Gutierrez MA</u>		23B. DATE SIGNED <u>6-2-70</u>		23C. PHYSICIAN'S NAME (Type) <u>JULIO GUTIERREZ MA</u>	
23D. ADDRESS <u>M.E.H.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>6-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>XXXXXX</u>		25C. FUNERAL DIRECTOR <u>XXXXXX Leonard J Ruck Inc Balto. Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

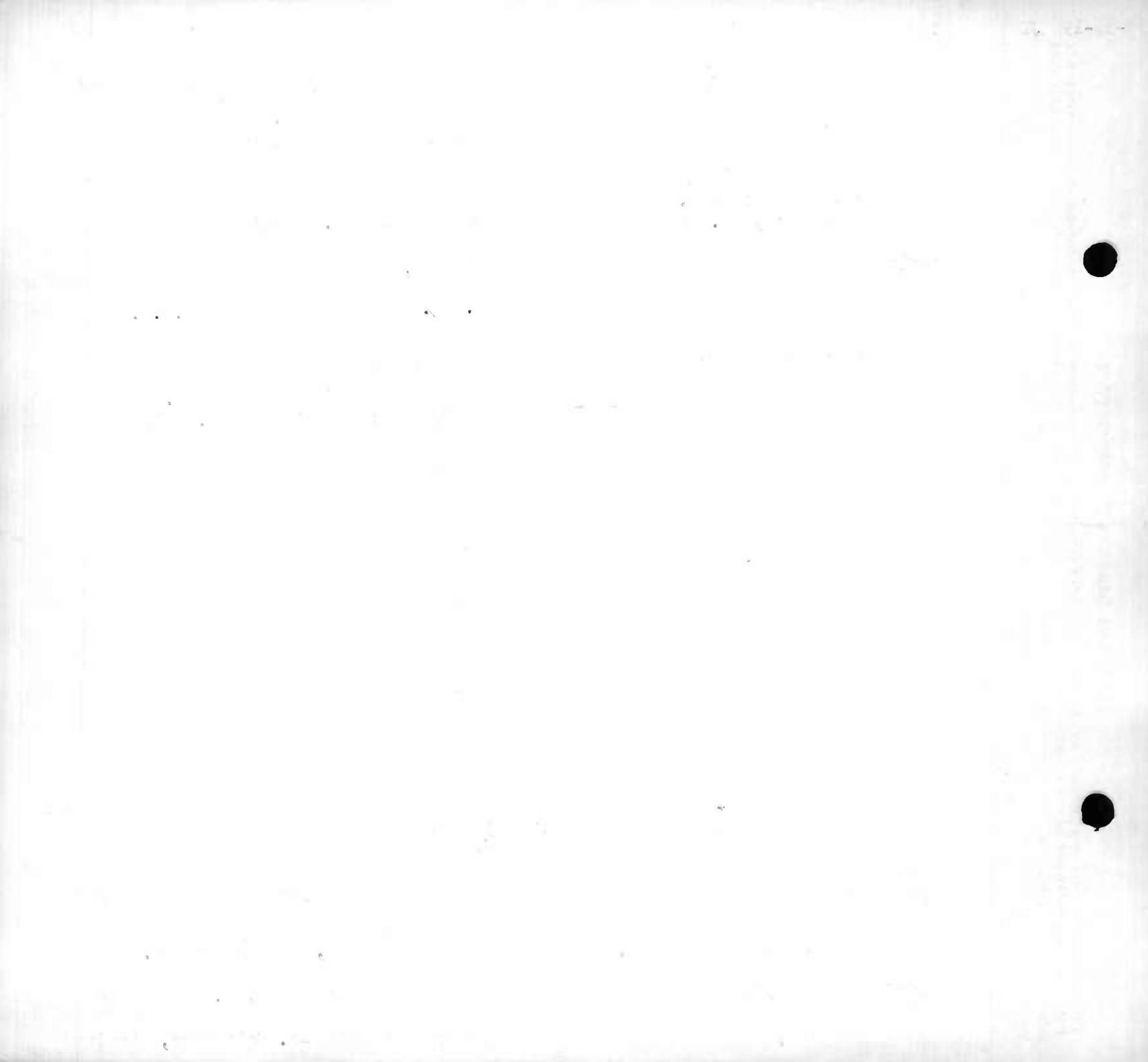
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5742</u>	
BIRTH NO. <u>S-512 70 5742</u>					
1. NAME OF DECEASED (Type or Print) <u>George Simpson</u>		2. DATE AND HOUR OF DEATH <u>9:15 AM 6/2/70</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>33 Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>8106 Old Philadelphia Road</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/37</u>	9. AGE (in years last birthday) <u>33</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George L. Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Norma Thompson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-32-8543</u>		17. INFORMANT <u>Mrs. Patricia M. Simpson</u>	
				ADDRESS <u>(Same)</u>	
18. <u>250.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE: Cardiac respiratory arrest</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF: uremia, diabetes, CHF</u> <u>(C) _____</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>5/20</u> 19 <u>70</u> to <u>6/2</u> 19 <u>70</u> that <u>(A)</u> (we) last saw the deceased alive on <u>6/2</u> 19 <u>70</u> and that <u>(A)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(A)</u> (We) (did) <u>(not)</u> view the body after death.					
23A. SIGNATURE <u>Loren G. Lipson, MD</u>		23B. DATE SIGNED <u>6/2/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Loren G. Lipson, MD</u>	
		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/70.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Cemetery</u>	
				24D. LOCATION <u>Belair, Baltimore, Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>John F. V. ...</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5743	
M-655 70 5743		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>NANCY Pearl MARY ANN</u>		7:30 PM 6/1/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		Maryland Baltimore 2636	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Female White		Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER	
Housewife		6608 Maple Ave. 21222 005	
10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9. AGE (In years last birthday)	
		April 17, 1896 74	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
W. Va.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benjamin Stewart		Rebecca Ross	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) III yes, give war or dates of service		16. SOCIAL SECURITY NO.	
No		232-10-7396D	
17. INFORMANT		ADDRESS	
BCH Records: Baltimore, Md. 21224		4940 Eastern Ave.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		SEPSIS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Urinary tract infection	
		(C) PARATUBERCULOSIS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Long STANDING	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2. 20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		Yes Yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. HOW DID INJURY OCCUR?	
21F. INJURY OCCURRED			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-18-1970 to 6-1-1970 that (I) (we) last saw the deceased alive on 6-1-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Arnold Levenson MD		6/1/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Arnold Levenson MD		Baltimore City Hospitals 4940 Eastern Ave. Baltimore Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		6/5/70	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Greenlawn		Clarksburg, West Virginia	
25A. DATE RECEIVED BY HEALTH DEPT.		25C. FUNERAL DIRECTOR	
JUN 5 1970		Leonard J Ruck Inc. Baltimore, Maryland	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5744	
BIRTH NO. 18-650 70 5744		BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print)		BROWN, HELEN ELIZABETH		2. DATE AND HOUR OF DEATH JUNE 01, 1970 11:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND HOWARD COUNTY	
ST. AGNES HOSPITAL		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
40 CATON & WILKENS AVENUES		ELKRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
BALTIMORE, MD. 21229		E. STREET AND NUMBER		5409 MAIN ST.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-03-15	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
INSPECTOR		MONARCH, INC.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE W. CLARK		AMELIA ROEBAUGH		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-12-3929		ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Circulatory Collapse 72 hrs.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Myocardial Infarction	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		Coronary Occlusion	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2/1/70				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
1 Month 1 Day 1 Year (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MAY 30 19 70 to JUNE 1 19 70 that (X) (we) last saw the deceased alive on JUNE 1 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (X) (X) (X) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
G. Patrick M.D.		06 01 70		G. PATRICK M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-5-70		Meadowridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 5 1970		Robert E. Taylor, Jr.		Wash. Blvd. & Donsey Rd. Balto. 5922 Du Alameda Balto. Md.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

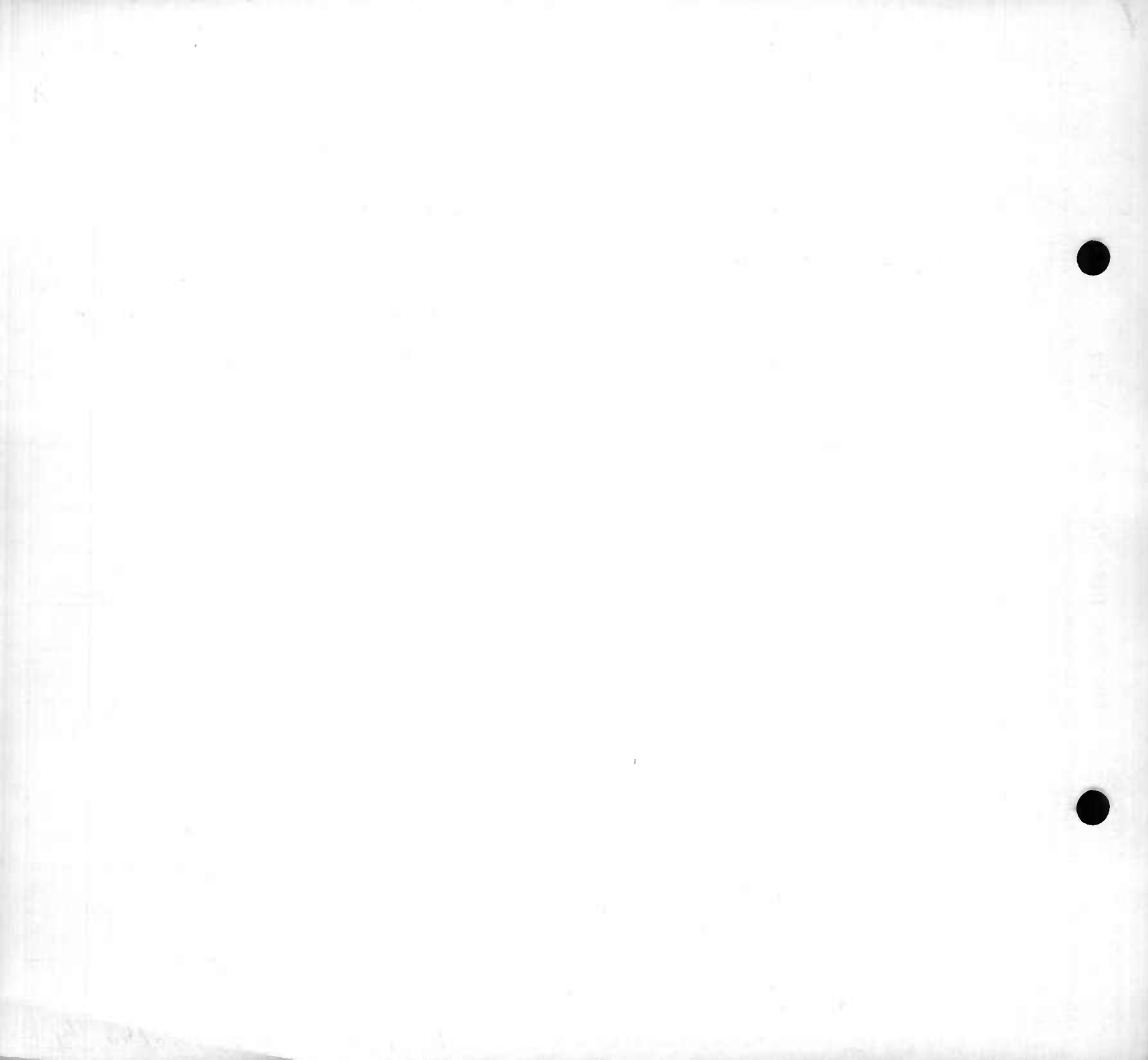
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5745</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>4-520</u>		70 5745			
1. NAME OF DECEASED (Type or Print) <u>Bertie Daine</u>			2. DATE AND HOUR OF DEATH <u>6/3/70</u> <u>11:15 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence below admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Chinook Hospital</u>			8. COUNTY <u>md</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2539 W Baltimore St</u>		
5. SEX <u>F</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/09</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph Barrett</u>			14. MOTHER'S MAIDEN NAME <u>Clarence Hammond</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chant</u>
18. <u>207.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis</u> (B) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>MP</u> (this hospital) attended the deceased from <u>5/4/70</u> 19 to <u>6/3/70</u> 19 that (I) <u>we</u> last saw the deceased alive on <u>6/3/70</u> 19 and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>E. Sears Jr. MD</u>			23B. DATE SIGNED <u>6/3/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>E. Sears Jr. MD</u>			23D. ADDRESS <u>225 Greene St</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-8-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION <u>Arbutus</u>		24E. (City, town, or county) <u>md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>	
ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5746</u>
BIRTH NO. <u>5-000 70 5746</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Charles Shaw</u>		2. DATE AND HOUR OF DEATH <u>6/3/70</u> <u>12 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Mercy</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1502</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1708 N. Monroe St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1913</u>	9. AGE (in years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Shaw</u>		
14. MOTHER'S MAIDEN NAME <u>Ida Perkins</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>John E. Shaw</u>		
18. <u>4/12/4</u> I		ADDRESS <u>1708 N. Monroe St.</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>DISEASE</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>2) Left side C.V.A</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> 19 <u>70</u> to <u>6/2</u> 19 <u>70</u> that (I) <del>we</del> last saw the deceased alive on <u>6/1</u> 19 <u>70</u> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.				
23A. SIGNATURE <u>H. MAKIPOU</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>HOUSHANG - MAKIPOU</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn Cem.</u>
24D. LOCATION <u>Balto.</u>		24E. FUNERAL DIRECTOR <u>E. Kray</u>		24F. ADDRESS <u>1000 Brantley Ave</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. ADDRESS <u>1000 Brantley Ave</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5747	
BIRTH NO. 70 5747		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CARLEY, CORRINE (Corinne)		2. DATE AND HOUR OF DEATH 6/3/1970 8.05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE.		A. STATE MARYLAND.		B. COUNTY 2720	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3800 MEMLO DR. #15.			
5. SEX F	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/89	9. AGE (In years last birthday) 80	10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George Baker		14. MOTHER'S MAIDEN NAME Sarah Hawkins		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-42-8892		17. INFORMANT ADDRESS Elaine C. Davis - 3800 Menlo Drive	
18. CAUSE OF DEATH					
<p>412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE CEREBRO VASCULAR ACCIDENT. 2 days.</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1/1970 to 6/3/1970 that (I) (we) last saw the deceased alive on 6/3/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. DEGREE		23B. DATE SIGNED 6/3/70.	
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-6-70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR [Signature]		24F. FUNERAL DIRECTOR Charles R. Law	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500 70 5748		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5748	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cooney Dorothea A.</i>		2. DATE AND HOUR OF DEATH <i>6/4/70 9 53 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1608</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>		E. STREET AND NUMBER <i>613 N. Woodington Road.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/29/89</i>	9. AGE (in years last birthday) <i>80</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Assmann</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Presser</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-32-9467</i>		17. INFORMANT <i>Bessie Cooney</i> ADDRESS <i>1317 Denbriht Rd. Balto, Md.</i>	
18. <i>412.3 I</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CORONARY HEART DISEASE</i>		(B) <i>Pulmonary embol</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) <i>Pulmonary emboli</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <i>no</i>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that <del>(H)</del> (this hospital) attended the deceased from <i>5-22</i> 19 <i>70</i> to <i>6-4</i> 19 <i>70</i> that (I) <del>(was)</del> last saw the deceased alive on <i>6-4-70</i> 19 <i>70</i> and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) (did not) view the body after death.	
23A. SIGNATURE <i>Sam C. Kerr M.D. ChD</i>		23B. DATE SIGNED <i>6-4-70</i>		23C. PHYSICIAN'S NAME (Type) <i>IAIN C. KERR M.D. ChD</i>	
23D. ADDRESS <i>BON SECOURS HOSP 2025 W FAYETTE ST #23</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/8/70</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JUN 5 1970</i>	
25B. NAME OF REGISTRAR <i>John E. J. Kelly</i>		25C. FUNERAL DIRECTOR <i>Witzke Inc.</i>		ADDRESS <i>1630 Edmondson Ave.</i>	

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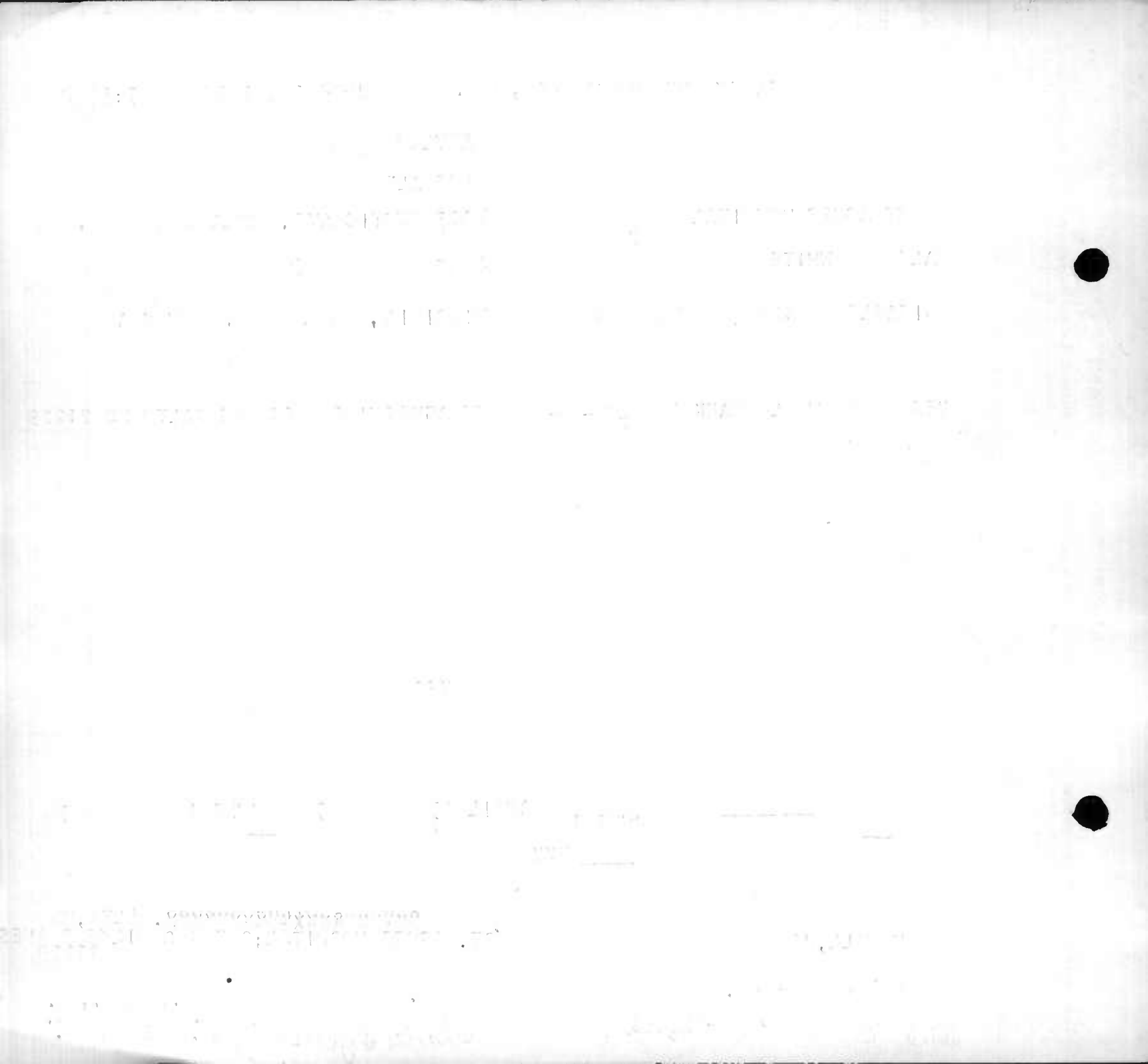
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 70 5749		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		X REG. NO. 70 5749	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BEATTY, HERMAN MOORE, SR.		JUNE 1, 1970 7:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL		MARYLAND		5300	
		C. CITY OR TOWN ROSEDALE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 04 25 08		9. AGE (In years last birthday) 62		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED (Retired)		10B. KIND OF BUSINESS OR INDUSTRY Aircraft Factory		11. BIRTHPLACE (State or foreign country) VIRGINIA, Front Royal.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME ? Beatty		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 2		16. SOCIAL SECURITY NO. 218-03-3222		17. INFORMANT ST AGNES HOSP RECORDS BALTO MD 21229	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: ASCUD (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from APRIL 27 19 70 to JUNE 1 19 70 that (I) (we) last saw the deceased alive on JUNE 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (not) view the body after death.		23A. SIGNATURE Herman N. Wall, Jr. M.D. 23B. DATE SIGNED 6-2-70	
24. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-5-70.		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION 5501 Frederick Ave., Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Charles J. Taylor		25D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVES 21229		25E. ADDRESS 901 S. Conowingo St. Balto., 21224, Md.	



T 242

70 5750

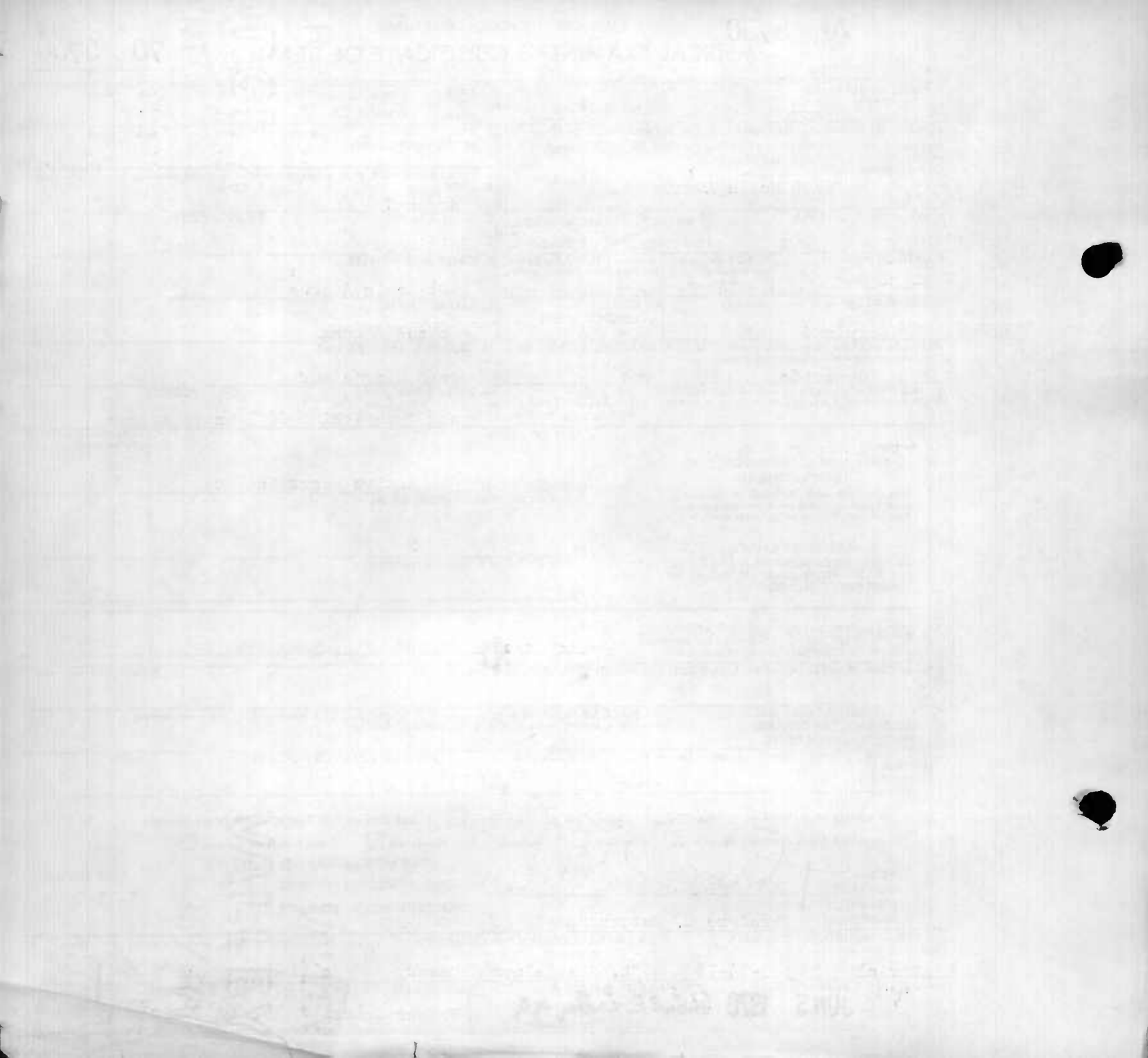
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5750

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Tucholski		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 5 11 70 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6601 Maple Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 11 70 10 A. M.	
6. SEX F		7. RACE W	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-15-1895		10. AGE (In years last birthday) 74	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Joann Clayheimer	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-09-3185	
18. INFORMANT Frank Tucholski		ADDRESS 6601 Maple Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.241.250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) HCVD DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Nature causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Theodore C. Patterson		DATE SIGNED 5-13-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-14-70	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Avenue	



6-653

BALTIMORE CITY HEALTH DEPARTMENT

70 5751

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5751

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM GRANT

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐Month  
5Day  
29Year  
70Hour  
2:45 a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

34 Bon Secours Hospital

3. DATE  
PRONOUNCED DEADMonth  
MayDay  
29, 1970

Year

Hour  
2:45 a

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2001

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 19, 1938

10. AGE (in years  
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1939 W. Lexington St.

11. BIRTHPLACE (State or foreign country)

Kentucky, S. Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Grant

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

Appt. House

15. MOTHER'S MAIDEN NAME

Janice Whitfield

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

241-32-6907

18. INFORMANT

Mrs. Sarah Wright

ADDRESS

1939 W. Lexington St.

19.

493 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Status asthmaticus

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

chronic bronchial asthma

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/29/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6-3-70

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Westport (Baltimore)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Joseph J. Jones

ADDRESS

2222 W. North Ave.





1  
5-162

70 5752

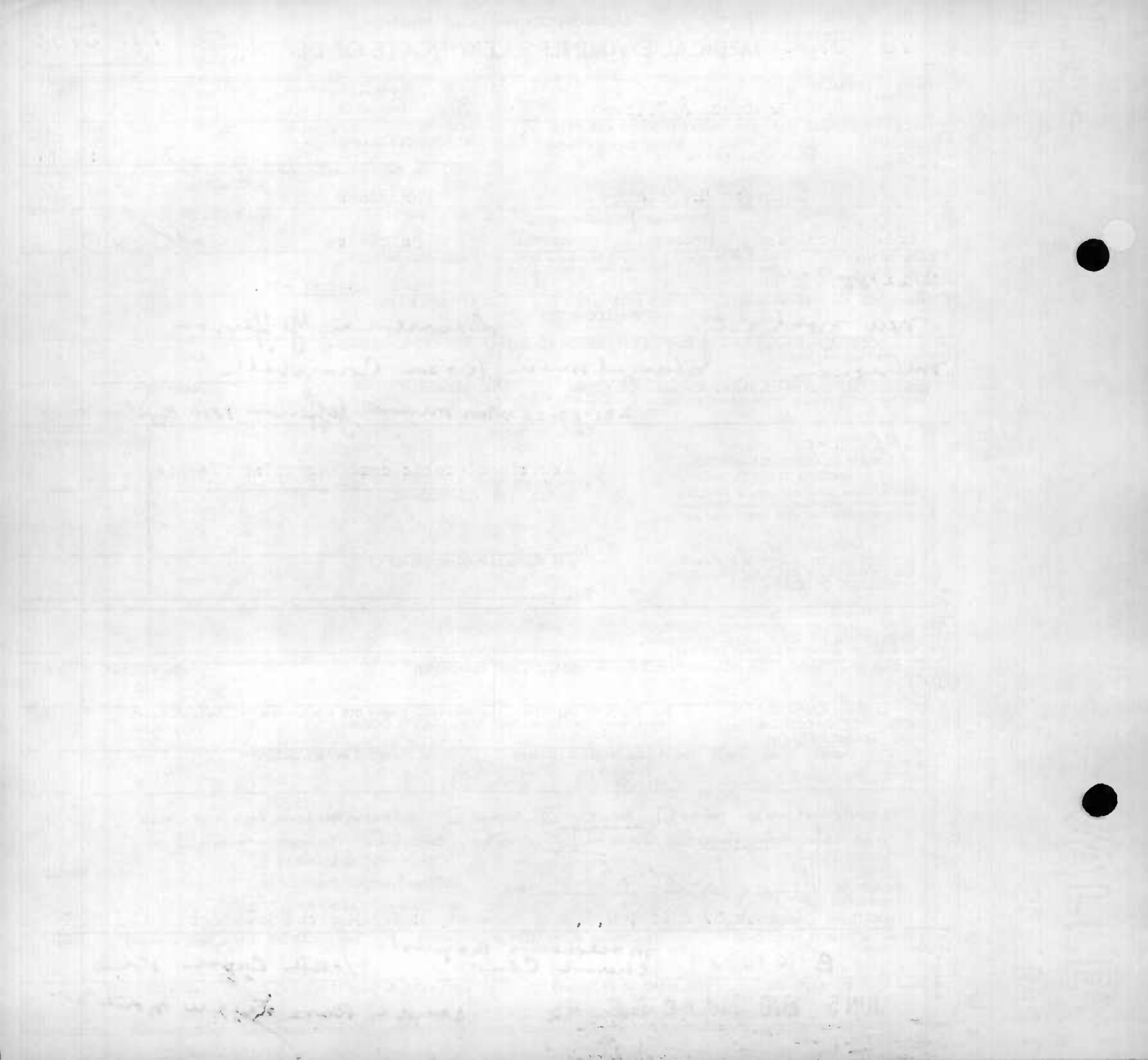
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 5752

REG. NO.

BIRTH NO.

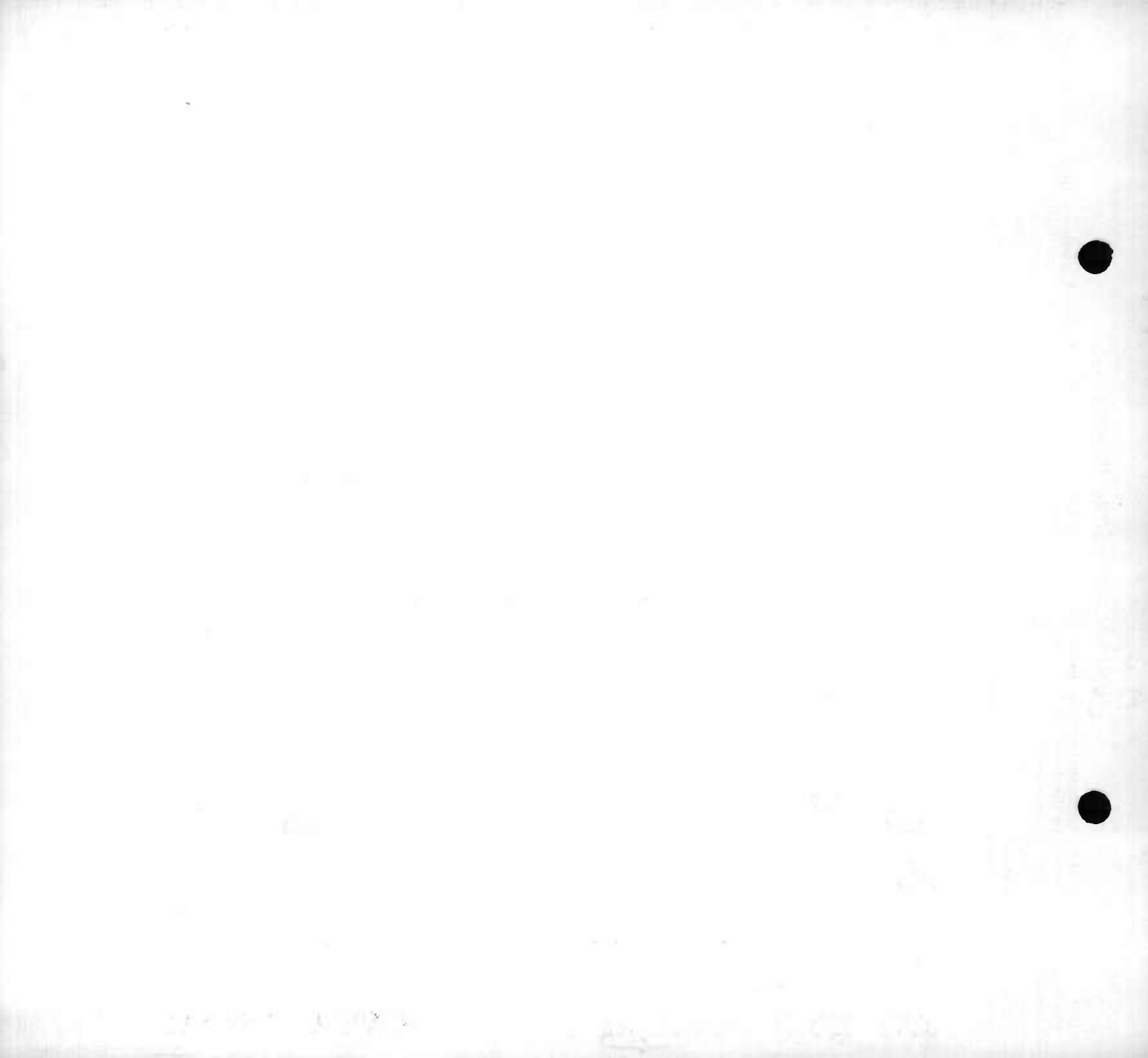
1. NAME OF DECEASED (Type or Print) <b>Lawrence Jefferson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>5 31 70 7:10 a. m.</b>	
6. SEX <b>male</b>		7. RACE <b>colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1503</b>	
9. DATE OF BIRTH <b>2/22/88</b>		10. AGE (In years last birthday) <b>82</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>musician</b>		15. MOTHER'S MAIDEN NAME <b>Rosa Campbell</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>231-20-2277</b>	
18. INFORMANT <b>Mrs. Mimi Jefferson</b>		ADDRESS <b>1810 Ruxton Ave.</b>	
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED <b>5/31/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>6-5-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>moedon church</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph E. Ruz</b>		ADDRESS <b>2222 W North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

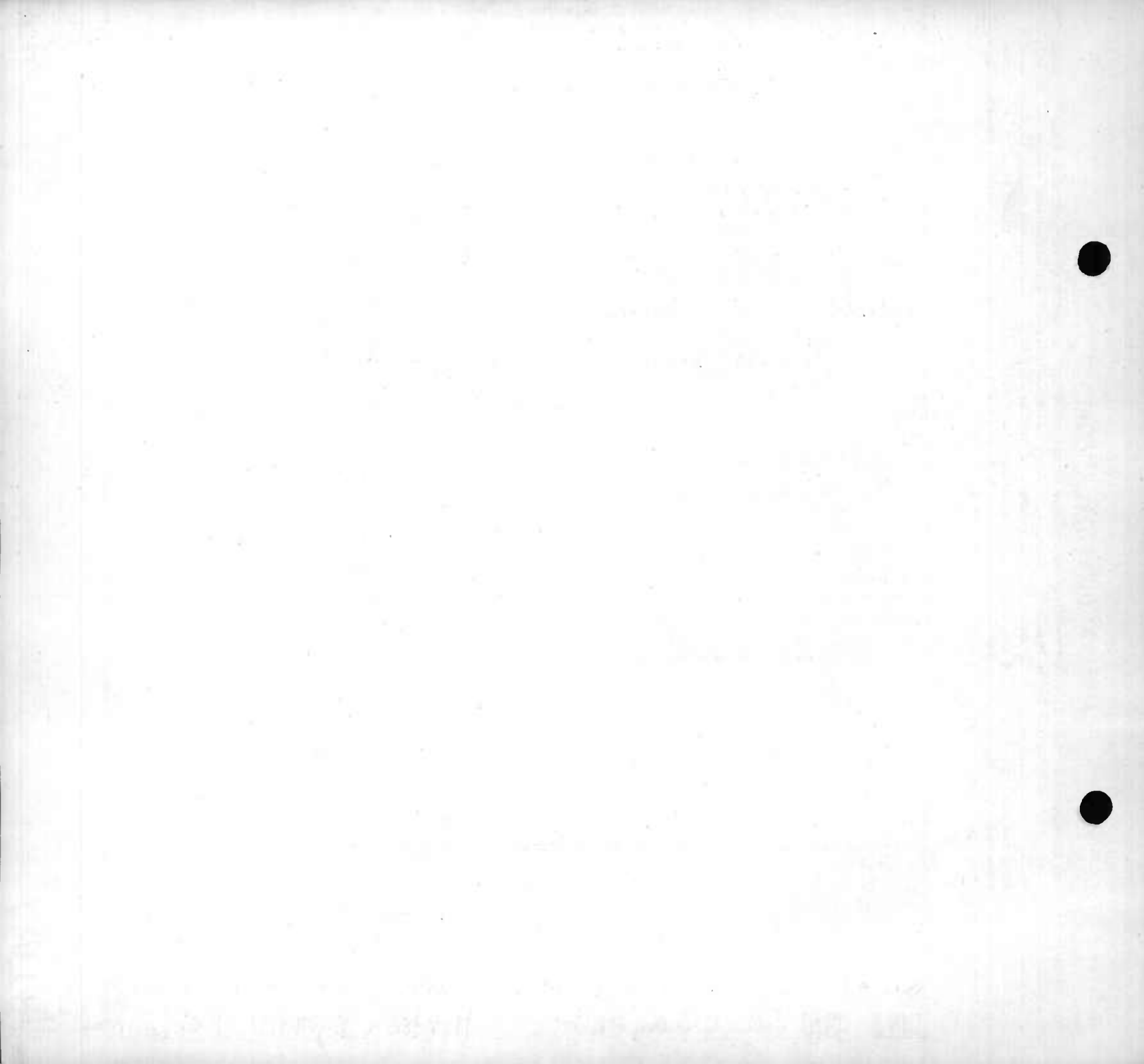
BALTIMORE CITY HEALTH DEPARTMENT				70 5753	
<div style="display: flex; justify-content: space-between;"> <span>C-200 70 5753</span> <span>BIRTH NO. 70-09080</span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <u>BABY BOY COX</u> (Dianne)			<b>2. DATE AND HOUR OF DEATH</b> <u>5/30/70</u> <u>930</u> A.M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore, City Hospitals</u> ADDRESS OR LOCATION <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>			<b>6. RACE</b> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/>		
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>5-26-70</u>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Robert</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Dianne House</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		
<b>17. INFORMANT</b> <u>BCH Records: Baltimore, Md 21224</u>			<b>18. CAUSE OF DEATH</b> <u>IDIOPATHIC RESPIRATORY DISTRESS SYNDROME</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PREMATURITY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>SEIZURE DISORDER</u> <u>DISSEMINATED INTRAVASCULAR COAGULATION</u>		
<b>19A. DATE OF OPERATION</b> <u>2</u>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>			<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>Yes</u>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from <u>5/26/70</u> 19<u>70</u> to <u>5/30</u> 19<u>70</u> that (I) (we) last saw the deceased alive on <u>5/30</u> 19<u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Carmela L Tardo MD</u>			<b>23B. DATE SIGNED</b> <u>5/30/70</u>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Carmela L. Tardo M.D.</u>			<b>23D. ADDRESS</b> <u>Baltimore, City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>24B. DATE</b> <u>6-1-70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Baltimore City Hospitals</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>		<b>24E. LOCATION</b> (City, town, or county) (State) <u>21224</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 5 1970</u>	
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Farber, Jr.</u>		<b>25C. FUNERAL DIRECTOR'S ADDRESS</b> <u>HOSPITAL DISPOSAL</u>		<b>25D. NAME OF REGISTRAR</b> <u>Robert E. Farber, Jr.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-550 70 5754 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5754	
1. NAME OF DECEASED (Type or Print) <b>HOWARD A. BOWMAN A.</b>			2. DATE AND HOUR OF DEATH <b>6-4-1970 7 AM.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTIMORE MD 21216.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1538</b> C. CITY OR TOWN <b>BALTIMORE.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2402 ROSLYN ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1900</b>	9. AGE (In years last birthday) <b>69.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Charles Co. U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Bowman</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Adams</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>717-07-6444</b>		17. INFORMANT <b>THERESA GREEN</b> ADDRESS <b>2039 PENN AVE.</b>	
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebro-Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Cerebral Arteriosclerosis &amp; H.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>6-4-1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-19-1970</b> to <b>6-4-1970</b> , that (I) (we) last saw the deceased alive on <b>6-4-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul M. LAL, M.D.</b>			23B. DATE SIGNED <b>6-4-1970.</b>		
23C. PHYSICIAN'S NAME (Type) <b>PREM LAL, M.D.</b>			23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE MD 21216.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/6/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Moetow &amp; Dyett F.H.</b> ADDRESS <b>1701 Laurens St.</b>			



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5.512

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S-512

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5755

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ERNEST ERNIE SIMPSON OR SIMPKINS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month <b>6</b> Day <b>3</b> Year <b>70</b> Hour <b>8:05</b> a <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF DECEASED <b>ERNEST ERNIE SIMPSON</b> ADDRESS OR LOCATION <b>1421 Ward St. 2nd floor</b> <b>8-4-70</b>		3. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>3</b> , Year <b>1970</b> Hour <b>8:05</b> a <b>M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7-4-05</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Susie Brown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-07-7007</b>	
18. INFORMANT <b>Sadie Wren</b>		ADDRESS <b>715 Mt. Holly</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ✓ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Isidore Mihalakis</b> M.D. EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		21. AUTOPSY? (Yes or No) <b>no</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/3/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-6-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

V.S. 153

8-4-70

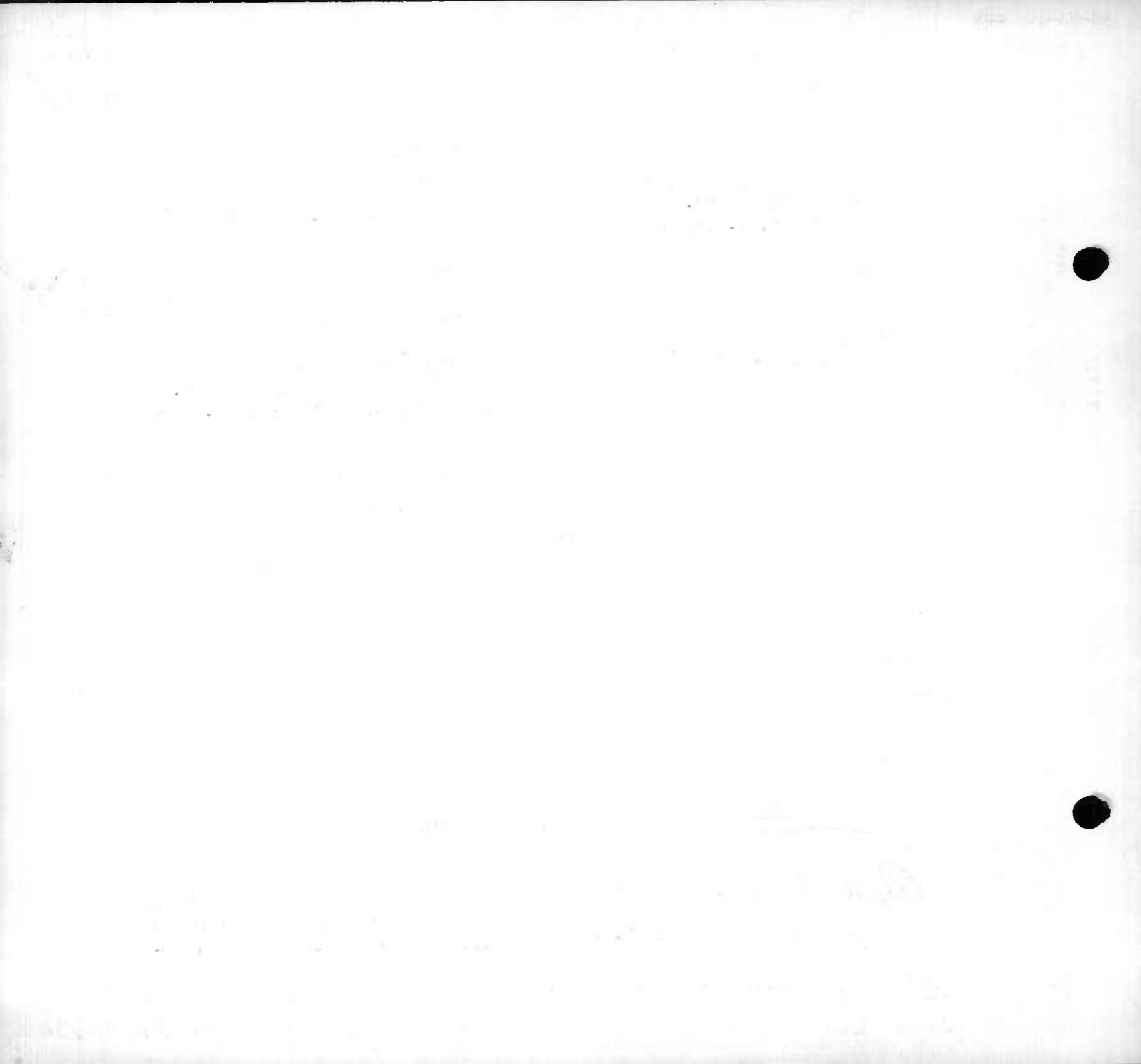
M.H.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-93-30		70 5756		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5756	
BIRTH NO. H-620				1. NAME OF DECEASED (Type or Print) <i>Elther Harris</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>6/3/70 9:50 P. M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
<i>31 Baltimore City Hospitals</i>				A. STATE <i>Maryland</i>			
<i>4940 Eastern Ave.</i>				C. CITY OR TOWN <i>Baltimore</i>			
<i>Baltimore, Md. 21224</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>Female</i>				8. DATE OF BIRTH <i>12-21-12</i>			
6. RACE <i>Negro</i>				9. AGE (in years last birthday) <i>57</i>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (State or foreign country) <i>Georgia</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William Black</i>				14. MOTHER'S MAIDEN NAME <i>Nethie Hill</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				17. INFORMANT <i>4940 Eastern Ave. Address</i>			
16. SOCIAL SECURITY NO.				BCH Records: Baltimore, Md. 21224			
18. <i>433.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Bilateral Cerebrovascular</i>			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF: <i>Accident - Probable Thrombosis</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Cerebrovascular Thrombosis - (D) Middle</i>			
				DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral artery</i>			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>				20A. AUTOPSY? (Yes or No) <i>YES</i>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21E. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21F. HOW DID INJURY OCCUR?			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> 19 <i>70</i> to <i>6/3</i> 19 <i>70</i>				and that (I) (we) last saw the deceased alive on <i>6/3</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date <i>6/3</i> 19 <i>70</i>			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arnold Levinson M.D.</i>				23B. DATE SIGNED <i>6/3/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Arnold Levinson M.D.</i>				23D. ADDRESS <i>Baltimore City Hospitals</i>			
23E. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23G. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23H. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23I. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23J. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23K. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23L. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23M. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23N. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23O. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23P. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23Q. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23R. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23S. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23T. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23U. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23V. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23W. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23X. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23Y. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23Z. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AR. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AS. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AT. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23AY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23AZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BR. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BS. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BT. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23BY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23BZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CR. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CS. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CT. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23CY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23CZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DE. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DF. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DG. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DH. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DI. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DJ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DK. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DL. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DM. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DN. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DO. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DP. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DQ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DR. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DR. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DS. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DS. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DT. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DT. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DU. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DV. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DW. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DX. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DY. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23DZ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23DZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EA. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EB. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EC. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23ED. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23ED. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EE. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EF. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EG. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EH. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EI. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EJ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EK. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EL. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EM. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EN. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EO. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EP. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EQ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23ER. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23ER. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23ES. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23ES. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23ET. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23ET. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EU. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EV. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EW. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EX. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EY. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23EZ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23EZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FA. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FB. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FC. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FD. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FE. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FF. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FG. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FH. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FI. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FJ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FK. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FL. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FM. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FN. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FO. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FP. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FQ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FR. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FR. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FS. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FS. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FT. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FT. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FU. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FU. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FV. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FV. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FW. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FW. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FX. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FX. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FY. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FY. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23FZ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23FZ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GA. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GA. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GB. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GB. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GC. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GC. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GD. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GD. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GE. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GE. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GF. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GF. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GG. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GG. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GH. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GH. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GI. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GI. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GJ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GJ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GK. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GK. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GL. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GL. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GM. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GM. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GN. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GN. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GO. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GO. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GP. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GP. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GQ. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23GQ. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
23GR. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				23			



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J-520 70 5757

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5757

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH A. JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2500 Huron St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 31 1970 2:15 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Glen Burnie	
9. DATE OF BIRTH 6-24-1900 69		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 5200	
10. AGE (In years last birthday)		E. STREET AND NUMBER 216 Evans St.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Maddox		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Priscilla		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 216-03-9987A		18. INFORMANT ADDRESS Sumner Davis 1310 Division St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-1-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-5-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY BALTIMORE HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

VS 151-REV. 1/1/68

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>70 5758 4</u>	
BIRTH NO. <u>70-08244 5758</u>		CERTIFICATE OF DEATH	
M.E. CASE NO. <u>70-08244 5758</u>		2. DATE AND HOUR OF DEATH <u>5/22/70 at 1:30 AM 1:30 AM</u>	
1. NAME OF DECEASED (Type or Print) <u>Terry Louise Rudasill</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> 6-25-70		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Dundalk</u>	
5. SEX <u>Female</u> 6. RACE <u>White</u>		D. STREET ADDRESS (If rural, give location) <u>7005 Dumber Rd. 21222</u>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>May 21, 1970</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) <u>4</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Donald Lee Rudasill</u>	
14. MOTHER'S MARDEN NAME <u>Sharon Louise Cougnet</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>IMMATURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.		(B) DUE TO	
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 21</u> 19 <u>70</u> to <u>MAY 22</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>MAY 22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Nam Do H Yang</u>		23B. DATE SIGNED <u>MAY 22, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>NAM DOH YANG</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-26-70</u>	
24C. NAME of CEMETERY or CREMATION		24D. LOCATION (City, town, county) (State)	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. DATE OF DEATH		25D. MORTUARY SERVICE - BCD	

Letter from Maryland General Hospital  
6-25-70 M.H.

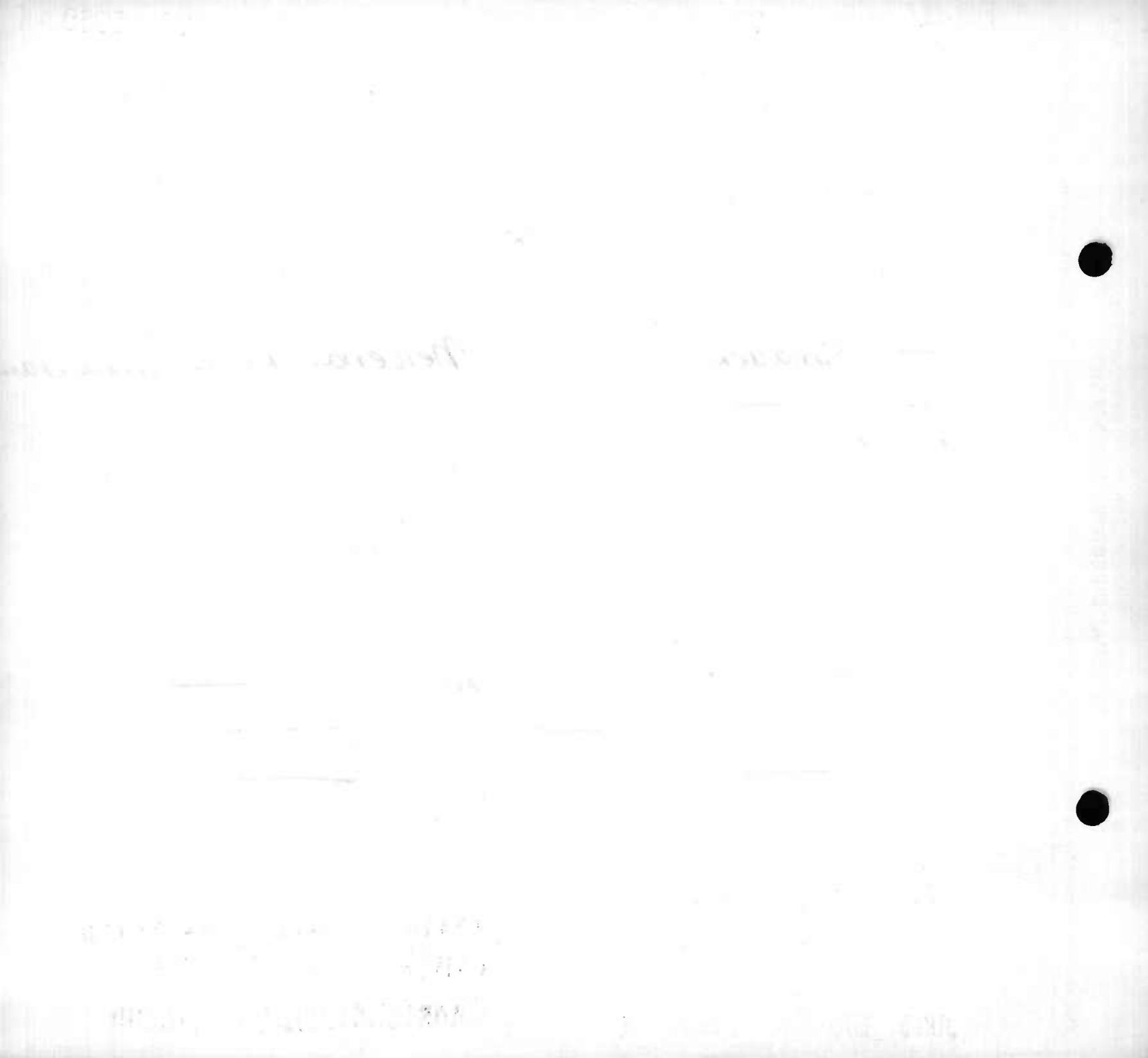
CERTIFICATE OF MARRIAGE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
JULY 1970

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 2em;">70 5759</span> <span style="float: right;">4</span>	
BIRTH NO. <span style="font-size: 2em;">S-545</span> <span style="font-size: 2em;">70 5759</span>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Smullen; Twin B</u>		2. DATE AND HOUR OF DEATH <u>10<sup>10</sup> PM 5/28/70</u> <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>		C. CITY OR TOWN <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/28/70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>20 min</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Smullen</u>	
14. MOTHER'S MAIDEN NAME <u>Melvena Rice Greenmount</u> <span style="float: right;">3919</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <span style="font-size: 2em;">769.4</span> <span style="font-size: 2em;">I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Anoxia = Cardiac Arrest</u> <span style="float: right;">1 min</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/28/70</u> 19__ to 19__		that (I) (we) last saw the deceased alive on 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Jan S. Vangrov MD</u>		23B. DATE SIGNED <u>5/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jan S. Vangrov MD</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-4-70</u>	
24C. NAME OF CEMETERY OR CREMATOR		24D. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. ADDRESS		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 5760</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">B-164 70-08765 5760</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.5em;">5-26-70 9:42</span>		
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.5em;">Beverly baby girl</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.5em;">MD</span> B. COUNTY <span style="font-size: 1.5em;">HOWARD</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">38 University Hoz of MD</span>		<b>C. CITY OR TOWN</b> <span style="font-size: 1.5em;">Laurel</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.5em;">405 Grant Av Laurel MD 20606</span>		
<b>5. SEX</b> <span style="font-size: 1.5em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">C</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">5-24</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">2</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.5em;">University Hoz</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.5em;">William Beverly</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.5em;">Karen Brooks</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.5em;">Dr A B Bourn</span>
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">2 day</span>
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.5em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> Indefinite medical examined <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">5-24</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">5-26</span> 19 <span style="font-size: 1.5em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">6 PM</span> 19 <span style="font-size: 1.5em;">70</span> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Khawle ahha</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">5-26</span>
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em;">KAWLA A B Bourn</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BOARD</span>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <span style="font-size: 1.5em;">6-4-70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">JUN 5 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">Robert E. Taylor</span>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 5761</b> <span style="float: right;">4</span>	
BIRTH NO. <b>S-353 70 5761</b> <span style="float: right;">70-08749</span>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Stanton</b>		2. DATE AND HOUR OF DEATH <b>5/21/70 4 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>920 Bennett Place</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>infant</b>	9. AGE (In years last birthday) <b>5 years</b>
13. FATHER'S NAME <b>Sonny Freeland</b>		14. MOTHER'S MAIDEN NAME <b>Stanton</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Cunkumach</b>	
18. <b>777 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity (non-viable)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2 no</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 21</b> 19 <b>70</b> to <b>May 21</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>May 21</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Cunkumach MD</b>		23B. DATE SIGNED <b>5/21/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
		<b>ANATOMY BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. NAME OF CEMETERY or CREMATORY	
<b>6-4-70</b>		<b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
<b>JUN 5 1970</b>		<b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
<b>MORTUARY SERVICE - BCB</b>			

[REDACTED]

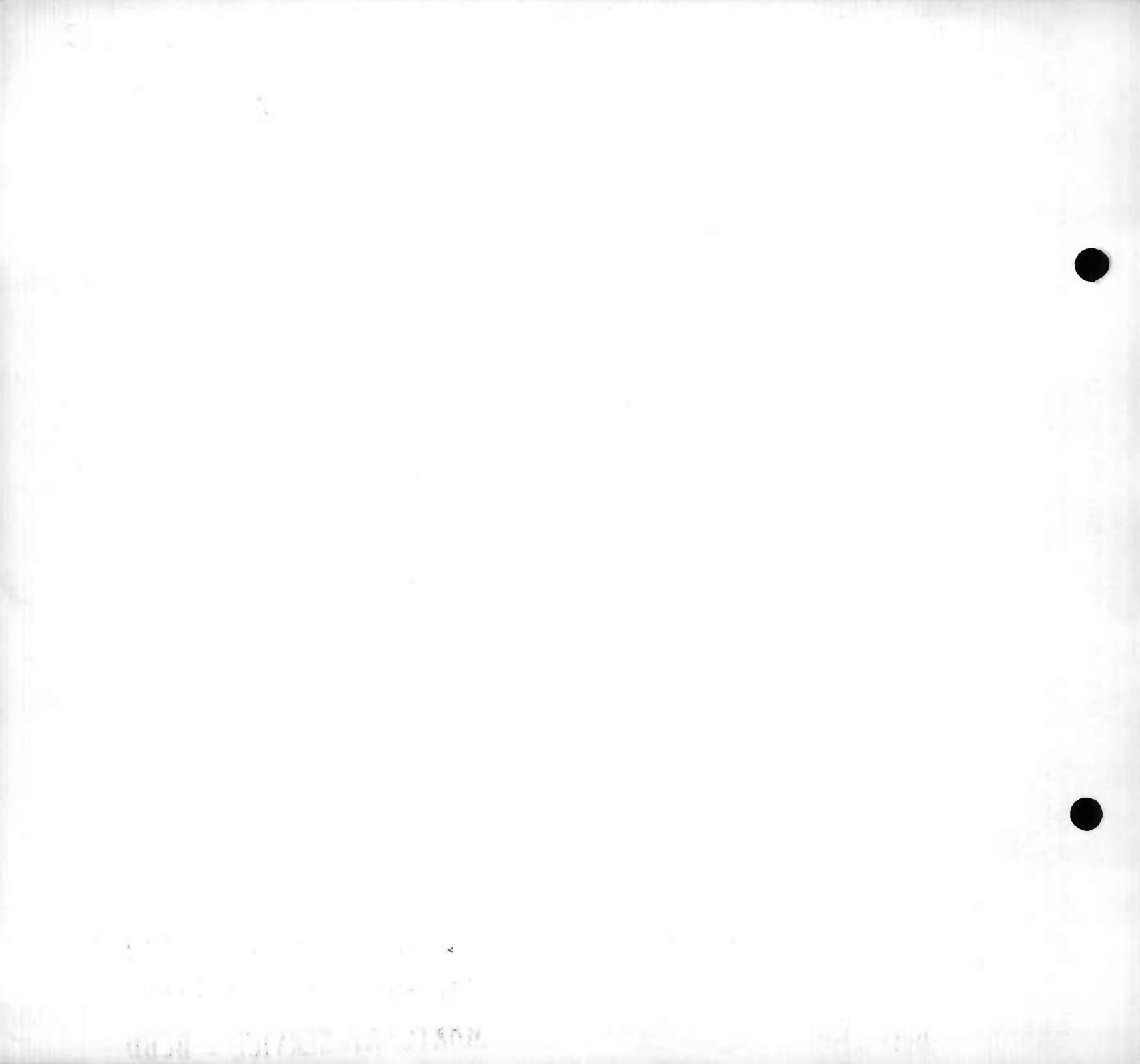


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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

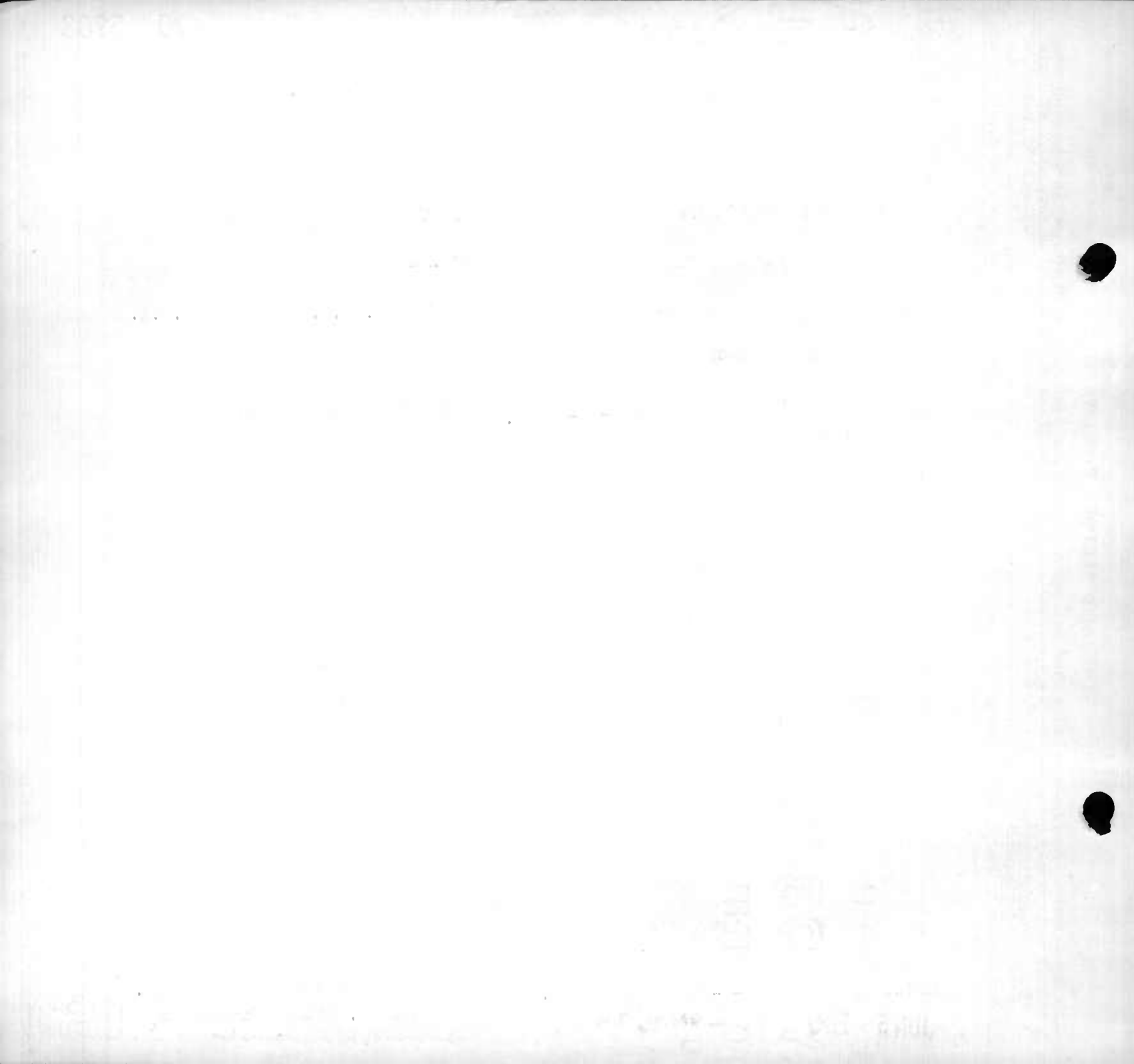
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5762</u>
<b>M-200</b> <b>BIRTH NO.</b> <u>70-08863</u> <b>70 5762</b>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Baby Boy Mack</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>May 28, 1970</u> <u>10:00 A</u> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21217 1303</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2312 Eutaw Place</u>		
<b>5. SEX</b> <u>male</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 28</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>9. AGE</b> (In years last birthday) <u>5 1/2</u> If Under 1 Yr. Months: Days: Hours: Min.
<b>11. BIRTHPLACE</b> (State or foreign country) <u>University of Md Hosp</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MARDEN NAME</b> <u>Connie Mack</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Connie Mack</u> <u>2312 Eutaw Pl, Apt 1</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <u>RDS</u> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <u>YES</u>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>May 28 4:34</u> <b>19 70</b> <b>to</b> <u>May 28 10:00</u> <b>19 70</b> <b>that (I) (we) last saw the deceased alive on</b> <u>May 28</u> <b>19 70</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Shih-Wen Huang, MD</u>		<b>23B. DATE SIGNED</b> <u>May 28, 70</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>SHIH-WEN HUANG MD</u>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <u>6-4-70</u>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 5 1970</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fisher, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <u>MORTUARY SERVICE - BODM</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 5763</span>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">70 5763</span>	
1. NAME OF DECEASED (Type or Print) <b>Willie Mae Wilson</b>				2. DATE AND HOUR OF DEATH <b>May-27th, 1970</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>2003</b>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>2007 West Baltimore Street</b>			
5. SEX <b>Female</b>	6. RACE <b>American</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April-1-1896</b>		9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Halifax Co. N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Clay Faulcon</b>				14. MOTHER'S MAIDEN NAME <b>Pattie Faulcon Snow</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>243-07-5625A</b>		17. INFORMANT ADDRESS <b>Otis Wilson 4000 Belle Avenue</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> <b>A. S. C. V. D.</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-12-1968</b> to <b>5-28-1970</b> , that (I) (we) last saw the deceased alive on <b>5-19-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Dr. Barbu Calin</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-28-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>BARBU CALIN</b>		23D. ADDRESS <b>831 Pylor Grove Baltimore</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June-1-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Stetson D. Wilson Funeral Home</b>		ADDRESS <b>113 W. Bath, Md.</b>	

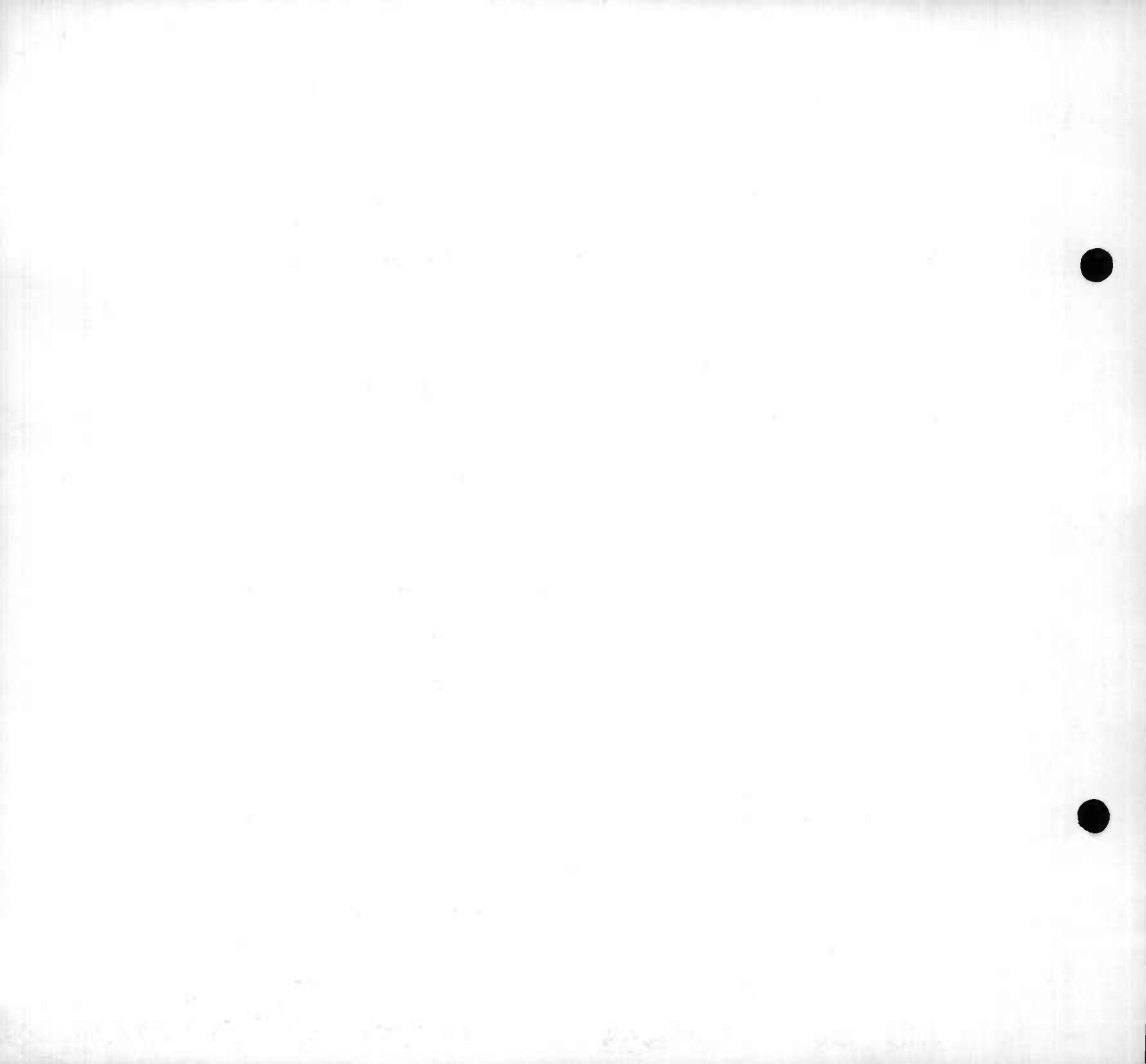




# FUNERAL DIRECTOR: IMPORTANT

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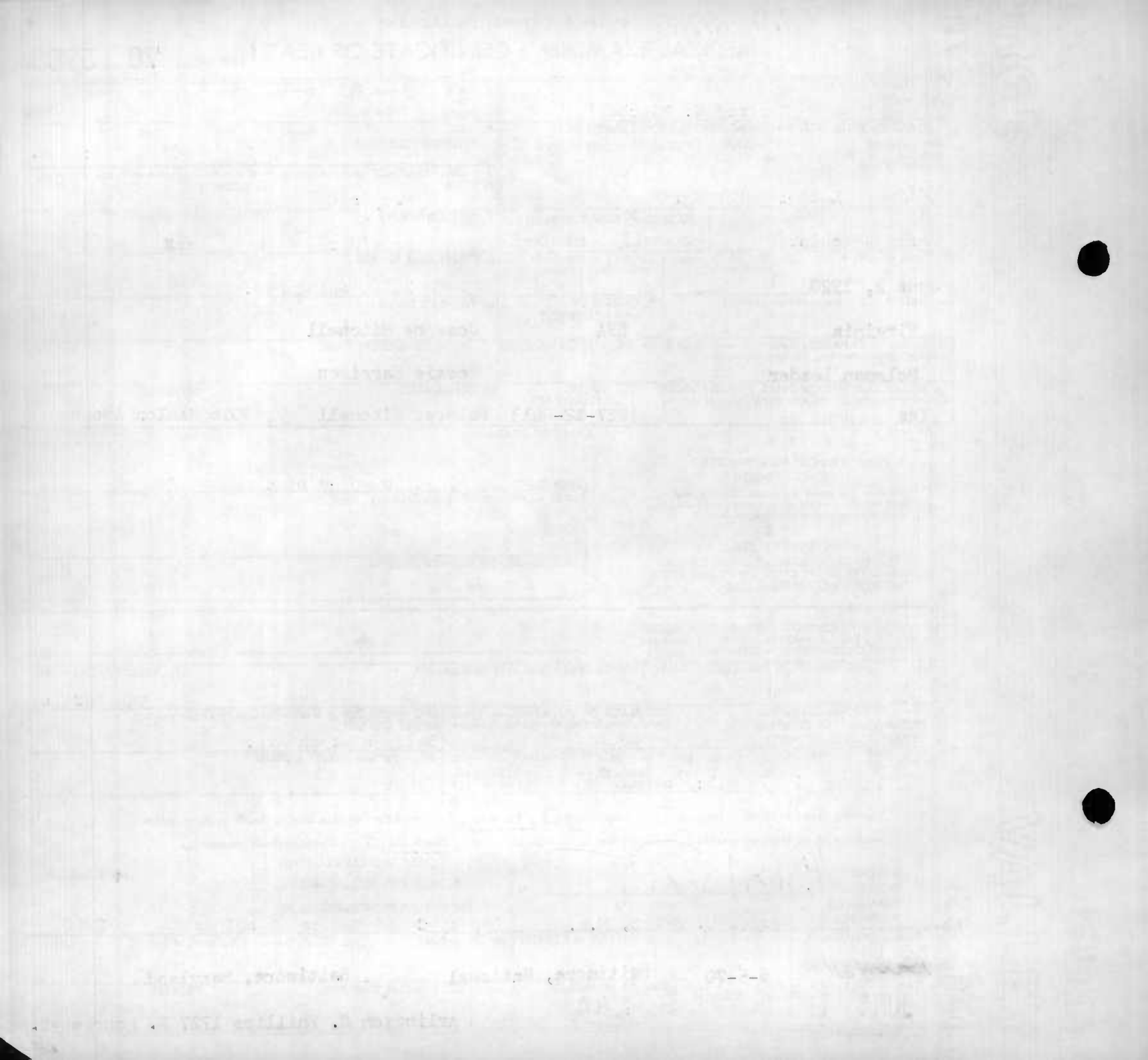
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5764	
BIRTH NO. 15-260		70 5764		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Linwood Booker (Theodore)</u>			2. DATE AND HOUR OF DEATH <u>6/3/70</u> <u>6:20</u> <u>4 M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1703</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9/14/1914</u> 9. AGE (In years last birthday) <u>55</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Theodore Booker</u>			14. MOTHER'S MAIDEN NAME <u>Mary Mattox</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> 27 Aug 42 - 7 Dec 45			16. SOCIAL SECURITY NO. <u>230-05-6142</u>		
17. INFORMANT <u>Sister Hazel Howell</u>			ADDRESS <u>2127 - Lynhurst Ave</u>		
18. <u>582X</u> I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE <u>Uremia</u>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) <u>Chronic Renal Insufficiency</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
II			(C) <u>Hypertensive Cardiovascular Disease</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Hypertensive Cardiovascular Disease</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11 May</u> 19 <u>70</u> to <u>3 June</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3 June</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blackmon, M.D.</u> DEGREE				23B. DATE SIGNED <u>3 June 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackmon, M.D.</u> DEGREE				23D. ADDRESS <u>Provident Hospital, Balt. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>6-5-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Blandford</u>	
24D. LOCATION (City, town, or county) <u>Petersburg</u>		24E. STATE <u>U.A.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>William S. Phillips</u> ADDRESS <u>1727 N. Monro St.</u>	



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. 70 5765 REG. NO. 70 5765

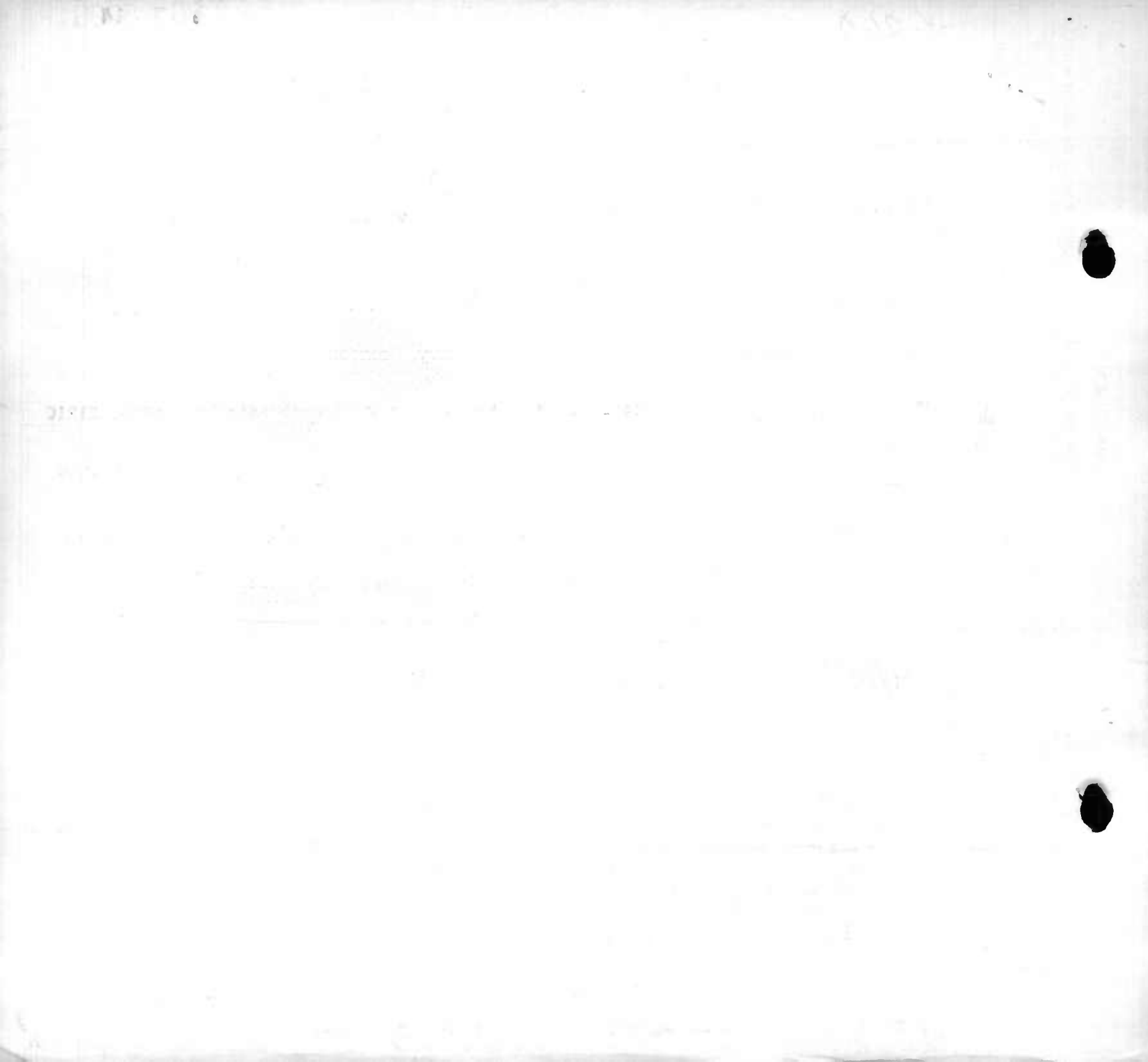
1. NAME OF DECEASED (Type or Print) <b>Bernard W. Mitchell</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 2 70 1:15 a.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 2 70 1:15 a.</b>	
6. SEX <b>male</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>colored</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 2, 1920</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) <b>50</b>		E. STREET AND NUMBER <b>3016 Hanlon Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josephe Mitchell</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moleman Leader</b>	
15. MOTHER'S MAIDEN NAME <b>Bessie Harrison</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>227-12-0413</b>		18. INFORMANT <b>Delores Mitchell</b>	
19. CAUSE OF DEATH <b>E965X I</b>		ADDRESS <b>3016 Hanlon Avenue</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes Partial</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>house</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>3413 Walbrook Ave. 1506</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>6 2 70 12:50am</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>shot</b>	
23. Partial			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		DATE SIGNED <b>6/2/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-5-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore, National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		ADDRESS <b>1727 N. Monroe St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">707 5766</span>
BIRTH NO. <span style="float: right;">K-260 70 5766</span>				
1. NAME OF DECEASED (Type or Print) <span style="float: right;">RUTH C. ROSSER</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">6/2/70 1:10 PM M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">33</span> The Johns Hopkins Hospital		A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">2714</span>		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 5 Beachdale Road 21210		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/14	9. AGE (In years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Albany, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frederick Ikana		14. MOTHER'S MAIDEN NAME Mary Warner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-2978		17. INFORMANT Wm N. Rosser 5 Beechdale Rd. Balto. 21210
18. <span style="float: right;">39111 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="float: right;">CNS bleed, prob.</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="float: right;">CHF + Renal Failure</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="float: right;">ARF with Dialysis Replacement</span>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">24 hrs</span>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<span style="float: right;">Portal HBP 2° B</span>		
19A. DATE OF OPERATION <span style="float: right;">6/4/74</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">ARF + CHF</span>		20A. AUTOPSY? (Yes or No) <span style="float: right;">0 NO</span>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <span style="float: right;">3/11</span> 19 <span style="float: right;">70</span> to <span style="float: right;">6/2</span> 19 <span style="float: right;">78</span> that (1) (we) last saw the deceased alive on <span style="float: right;">6/2</span> 19 <span style="float: right;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="float: right;">D. Furst MD</span>		23B. DATE SIGNED <span style="float: right;">6/2/70</span>		
23C. PHYSICIAN'S NAME (Type) DANIEL E. FURST		23D. ADDRESS JHH Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/5/70	24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	24D. LOCATION Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970	25B. NAME OF REGISTRAR Robert E. Taylor, R.A.	25C. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-635</u>				Baltimore City Health Department				REG. NO. <u>70 5767</u>			
1. NAME OF DECEASED (Type or Print) <u>MRS. CATHERINE MARTIN</u>				2. DATE AND HOUR OF DEATH <u>MAY 29, 1970 1:50 A.</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>V-29</u>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>EDGEWOOD NURSING HOME</u> <u>6000 BELLONA AVE</u>				C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>6000 BELLONA AVE</u>							
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 28, 1886</u>		9. AGE (in years last birthday) <u>83</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN SCHMIDT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH FEHLINGER</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. D.L. BAILEY 1818 BLAKEFIELD CR.</u>					
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral vascular occlusion</u> (B) <u>Cerebral arteriosclerosis</u> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>? years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Apr 13 1970</u> to <u>May 29 1970</u> that (I) (we) last saw the deceased alive on <u>May 27 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Frederick J. Vollmer MD.</u>								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5-29-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER MD.</u>								23D. ADDRESS <u>6100 YORK RD, BALTO. MD 21212</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>6/1/70</u>		24C. NAME of CEMETERY or CREMATORY <u>LUTHERAN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>WOODHAVEN, N. Y.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Bailey, R.D.</u>				25C. FUNERAL DIRECTOR ADDRESS <u>MITCHELL-WIEDEFELD HOME 6500 YORK RD.</u>			

8806 Woodhaven Ave  
Woodhaven, New York  
Admitted to N.H. 4/90.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 5768</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">G-645</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Emma B. Grullemeyer</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">90 Harford Gardens N.H.</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">May 27th, 1970</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Officer (pres.)</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Heating Co.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.5em;">2741</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">4620 Crosswood Avenue</span>	
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">NEW JERSEY</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Johann Barth</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Frances Holzapfel</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-09-5034 D</span> <span style="font-size: 1.2em;">213-28-9198</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Marian G. Haddock (Daughter)</span> <b>ADDRESS</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.5em;">Cerebral Arteriosclerosis 70 years</span> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> <span style="font-size: 1.5em;">Squidly</span> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Jan 20, 1950</span> <b>to</b> <span style="font-size: 1.2em;">May 27, 1970</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">May 27, 1970</span> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">MB Levin MD</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">May 31, 1970</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Morris B. Levin</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">5/30/70</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Loudon Pk. Cem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Balto MD.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 5 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Mitchell-Wiedefeld Home</span> <span style="font-size: 1.2em;">6500 York Rd. 21212</span>			

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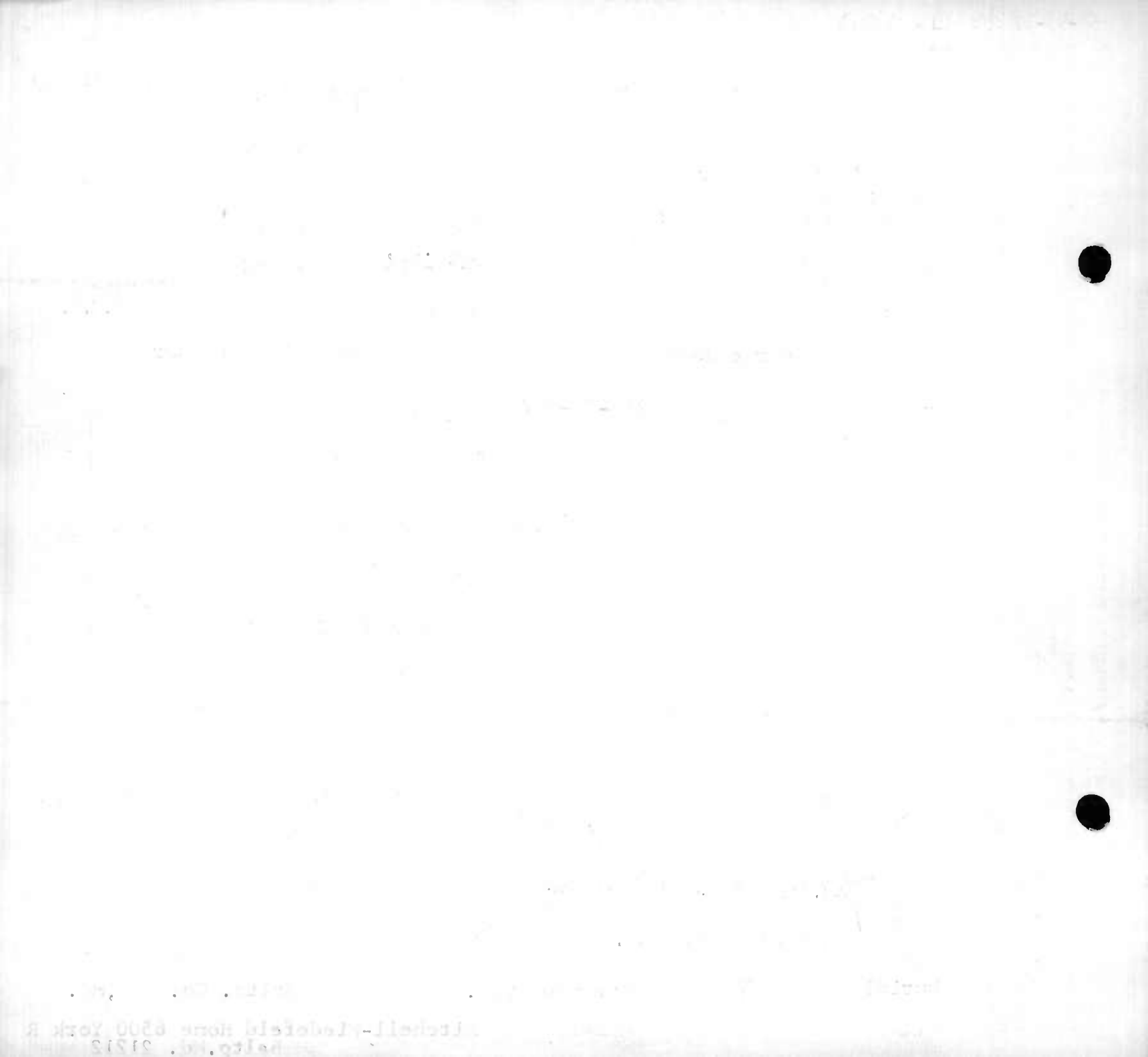
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56-93-19 djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
H-200		70		5769		70 5769	
1. NAME OF DECEASED (Type or Print) <i>Louise Hoch</i>				2. DATE AND HOUR OF DEATH <i>May 30, 1970 01:35 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Jan. 24, 1897</i>		9. AGE (In years, most birthday) <i>73</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>George Ross</i>			
14. MOTHER'S MAIDEN NAME <i>Catherine Grebner</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>219-58-4377</i>				17. INFORMANT <i>BCH: Records Baltimore, Maryland 21224</i>			
18. <i>436.9 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardiorespiratory arrest</i>				<i>acute</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebrovascular accident</i>				<i>1 week.</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Generalized Arteriosclerosis</i>				<i>years.</i>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>May, 26</i> 19 <i>70</i> to <i>May 30</i> 19 <i>70</i> that <i>(X)</i> (we) last saw the deceased alive on <i>May, 30</i> 19 <i>70</i> and that <i>(X)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) (did) (and not) view the body after death.							
23A. SIGNATURE <i>Francisco Tejada MD</i>				23B. DATE SIGNED <i>May, 30, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Francisco Tejada M.D.</i>	
23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>			
24B. DATE <i>6/2/70</i>				24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>	
25D. ADDRESS <i>6500 York Rd</i>				25E. ADDRESS <i>Balto. Md. 21212</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5770		70 5770	
C-450				70 5770		70 5770	
BIRTH NO.				70 5770		70 5770	
1. NAME OF DECEASED (Type or Print) <b>CULLEN, JOHN JOSEPH</b>				2. DATE AND HOUR OF DEATH <b>5-31-70 6:08 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVENUE 21229</b>				C. CITY OR TOWN <b>BALTI MORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1520 GREENDALE RD. BALTO</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-23-89</b>		9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pullman Company</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES CULLEN</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE REARDON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 18 8561</b>		17. INFORMANT ADDRESS <b>ST AGNES RECORDS WILKENS &amp; CATON</b>			
18. <b>402X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Congestive Heart Failure</i> <i>pulmonary edema</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>High blood pressure</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 hours</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>MAY 20, 1970</b> to <b>MAY 31, 1970</b> that <b>XX</b> (we) last saw the deceased alive on <b>MAY 31, 1970</b> and that <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (and not) view the body after death.							
23A. SIGNATURE <i>Dr. Gloria Boonswang</i> M.D.				23B. DATE SIGNED <b>31 May 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>DR. GLORIA BOONSWANG MD</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/3/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 5 1970</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld-Home</b>		ADDRESS <b>6500 York Rd/</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-653 70 5771				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 5771	
BIRTH NO. 70 5771				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				May 29th, 1970 9 P. M.			
FRIEDA M. TRINITE							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Gould Convalesarium				Maryland 1538			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2409 Elsinor Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Married		Mar. 20, 1895	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
75		Homemaker		Baltimore, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Otto N. Rosenbauer				Marie Pemsil			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				-----		Mr. Geo. M. Trinite (Husband)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
412.44 1250.9				Cerebrothrombosis		2 days	
ANTECEDENT CAUSES				Recurrent emboli			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic C-V disease		15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jan 21 19 70 to May 29 19 70, that (I) (we) last saw the deceased alive on May 29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
H. V. Harbold M.D.				June 1, 1970			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Harold V. Harbold				4706 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/2/70		Lorraine Pk. Cem.		Balto. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL HOME		ADDRESS	
JUN 5 1970		Robert E. Fisher, M.D.		Mitchell-Wiedefeld Home		6500 York Rd. 21212	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-465		70 5772		70 5772	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John L. Kellermann Sr.		5/30/70		11:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Balto.	
37 Mercy Hospital, Inc.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5010 Levindale Rd.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1898	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired BCPD		10B. KIND OF BUSINESS OR INDUSTRY Police		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Anton Kellermann		14. MOTHER'S MAIDEN NAME Catherine Roth	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 38 7188		17. INFORMANT Catherine Kellermann 5010 Levindale Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 577-94-070X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Gastric Retention DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 4 hr. 8 wks	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Viral Hepatitis					
19A. DATE OF OPERATION Sept. 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (this hospital) attended the deceased from _____ to _____ that (I) lost saw the deceased alive on _____ and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.		5/30/70		5/30/70	
23A. SIGNATURE George M. Pickel, M.D.		23B. DATE SIGNED 5/31/70		23C. PHYSICIAN'S NAME (Type) _____	
23D. ADDRESS _____		23E. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23F. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/70		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Woodlawn Balto.		24E. CITY, TOWN, OR COUNTY Md.		24F. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd	

8/10/70 Acute Gasue Retention  
due to hemorrhage into  
pancreas -  
Letter from Mercy Hospital  
in file - Bur. of Prisons - Am. Red  
Cross.

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5773</span>	
<div style="display: flex; justify-content: space-between;"> <span>70 5773</span> <span style="font-size: 1.5em;">70 5773</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Myrtle P. Sanborn		June 4, 1970 <span style="float: right;">3:45 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 4909 Arabia Ave			A. STATE <span style="font-size: 1.2em;">Maryland</span>		
			B. COUNTY <span style="font-size: 1.5em;">2743</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">4909 Arabia Ave</span>		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 27, 1890	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William T Harrod			Emma V. Wrightson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mr Garee M Sanborn <span style="float: right;">Same</span>	
18. <span style="font-size: 1.5em;">412.3 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ischemic Heart Disease</span>		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<span style="font-size: 1.5em;">Reported - Bronchitis</span>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1-3-70</span> 19 to <span style="font-size: 1.2em;">5-15</span> 1970, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-15</span> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Sebastian Russo</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">6/4/70</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Sebastian Russo M.D.		5017 Harford Rd Baltimore, Maryland			
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	6/8/70	Woodlawn CEMETERY	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 8 1970	Robert E. Farber, M.D.	Leonard J Ruck Inc. Baltimore, Maryland			

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# FUNERAL DIRECTOR: IMPORTANT

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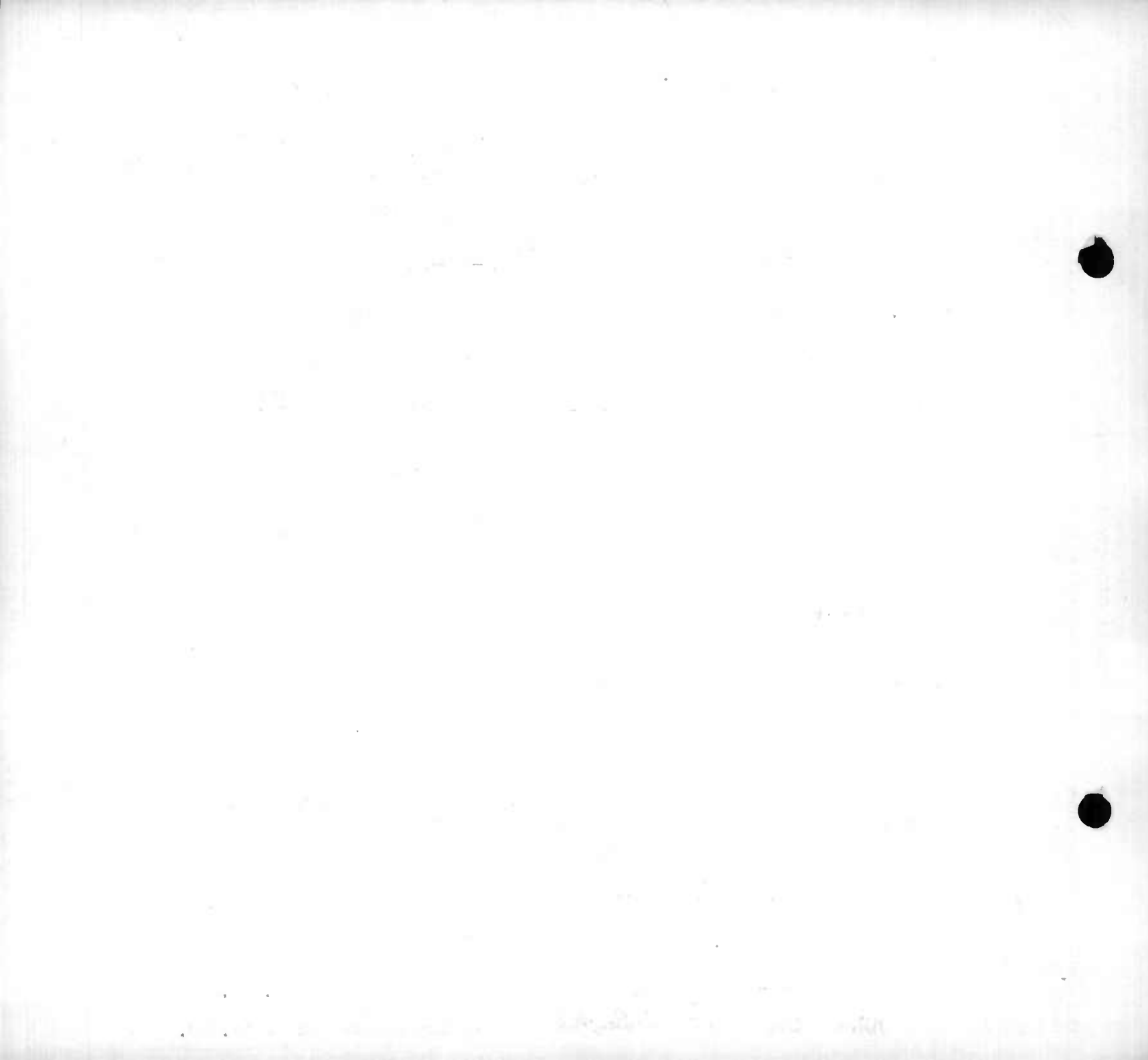
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5774	
BIRTH NO. 70-04697 70 5774		BIRTH CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL BARNARD</u>		2. DATE AND HOUR OF DEATH <u>6/4/70 5:45 AM 5<sup>45</sup> A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. &amp; BALT.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>42 8626 STURBRIDGE DRIVE</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/1/70</u>	9. AGE in years (last birthday) <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Bruce Barnard</u>		14. MOTHER'S MAIDEN NAME <u>Judith M. Manning</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Bruce K. Barnard</u>	
18. <u>776.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hyaline Membrane Dis</u> (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>None</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>from birth</u> <u>from birth</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NONE</u>					
19A. DATE OF OPERATION <u>6/4/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>6/1/70</u> to <u>6/4/70</u> 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>6/4/70</u> 19 <u>70</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward N. Zissman, M.D.</u>		23B. DATE SIGNED <u>6/4/70</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD N. ZISSMAN, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/8/70.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Calvary Cemetery</u>	
24D. LOCATION <u>Waltham, Mass.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1970</u>		25B. NAME OF REGISTRAR <u>James E. Gabley, R.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Buck, Inc. Balto. Md. 21214</u>	

6826 Starbridge Dr.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5775</u>	
70 5775				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George M. Wolf</u>		2. DATE AND HOUR OF DEATH <u>June 4, 1970</u>   <u>3 00</u> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> <u>906</u>		
C. CITY OR TOWN <u>BALTIMORE</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>2926 HARFORD ROAD</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-88</u>	9. AGE (in years last birthday) <u>82</u>	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. City Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ernest A Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Mary A Engelbach</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-1256</u>		17. INFORMANT <u>Mrs Stella Robinson</u> ADDRESS <u>7820 Hillsway Ave 21234</u>	
18. <u>10.94 185 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u> (B) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Prostatic carcinoma</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>(1) hour</u> <u>45 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>June 1</u> 19 <u>70</u> to <u>June 4</u> 19 <u>70</u> that <u>(1) (me)</u> last saw the deceased alive on <u>June 4</u> 19 <u>70</u> and that in <u>(my)</u> <u>(four)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(1) (me)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Thomas E Davis M.D.</u>				23B. DATE SIGNED <u>June 4, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>THOMAS E. DAVIS</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-9-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Balto. Md.</u>	

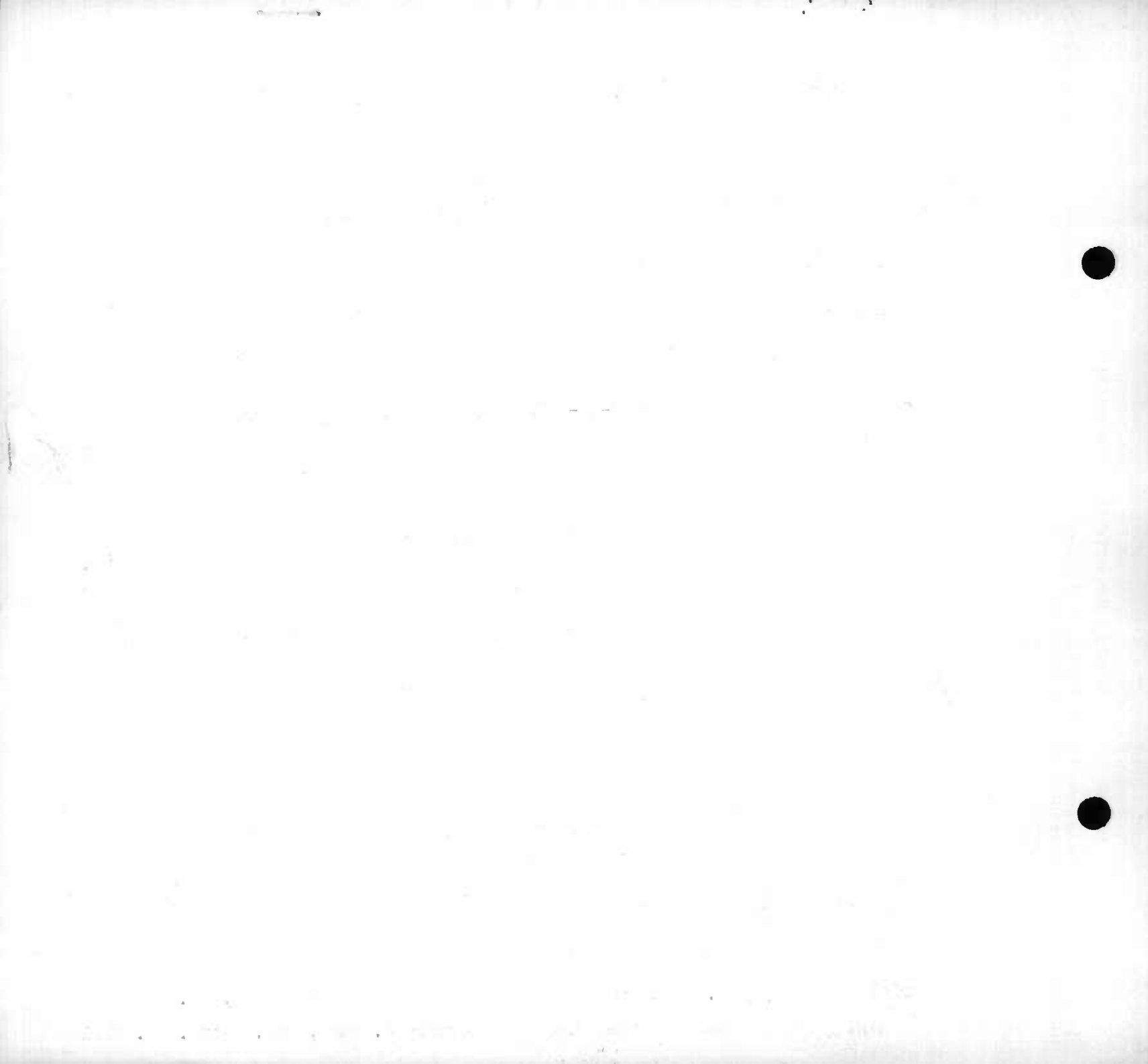




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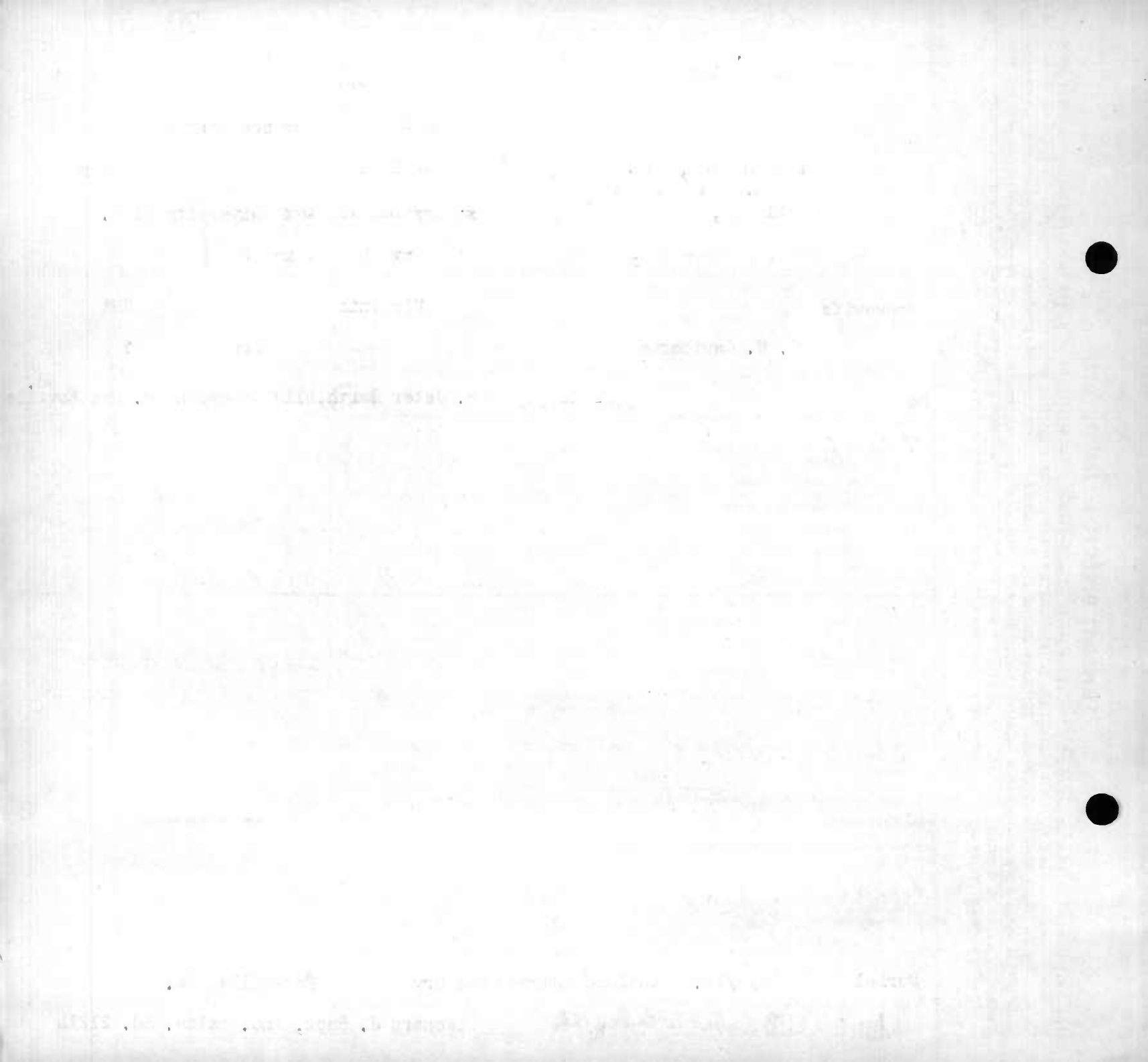
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 5776</span>
BIRTH NO. <span style="font-size: 1.5em;">70 5776</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARY L. FOWLER</span>		
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 4, 1970 10:15 P.</span>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <span style="font-size: 1.2em;">90 EDGEWOOD NURSING HOME</span>		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">831</span>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">90 EDGEWOOD NURSING HOME</span>		
6. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. STREET AND NUMBER <span style="font-size: 1.2em;">2725 Pelham Ave 21213</span>		9. SEX <span style="font-size: 1.2em;">Female</span>		
10. RACE <span style="font-size: 1.2em;">White</span>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. DATE OF BIRTH <span style="font-size: 1.2em;">10-8-80</span>		13. AGE (In years last birthday) <span style="font-size: 1.2em;">89</span>		
14. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		15. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
16. FATHER'S NAME <span style="font-size: 1.2em;">Frank Venturi</span>		17. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>		
18. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		19. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-46-8492</span>		20. INFORMANT <span style="font-size: 1.2em;">Miss Eleanor J. Fowler 2725 Pelham Ave.</span>
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">I</span> <span style="font-size: 1.2em;">250.9</span> <span style="font-size: 1.2em;">HYPOSTATIC PNEUMONIA</span>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">48 hrs</span>		
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span> <span style="font-size: 1.2em;">SEVERE GENERALIZED ARTERIOSCLEROSIS</span>		24. DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">10+ yrs</span>		
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">DIABETES MELLITUS</span>		26. DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">10+ yrs</span>		
27. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">DIABETIC GANGRENE RT FOOT</span>		28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 mos</span>		
29. DATE OF OPERATION <span style="font-size: 1.2em;">5-20-70</span>		30. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">amputation for gangrene</span>		31. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>
35. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		37. HOW DID INJURY OCCUR? <input type="checkbox"/>
38. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">Sept 5, 1969</span> to <span style="font-size: 1.2em;">June 4, 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">June 4, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.				
39. SIGNATURE <span style="font-size: 1.2em;">Frederick J. Vollmer MD</span>				40. DATE SIGNED <span style="font-size: 1.2em;">June 4, 1970</span>
41. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">FREDERICK J. VOLLMER MD</span>		42. ADDRESS <span style="font-size: 1.2em;">6100 YORK RD BALTO MD 21212</span>		
43. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		44. DATE <span style="font-size: 1.2em;">6/8/70.</span>		45. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Moreland Memorial Cemetery</span>
46. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		47. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. E. Gable, RD</span>		48. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>



FUNERAL DIRECTOR: IMPORTANT

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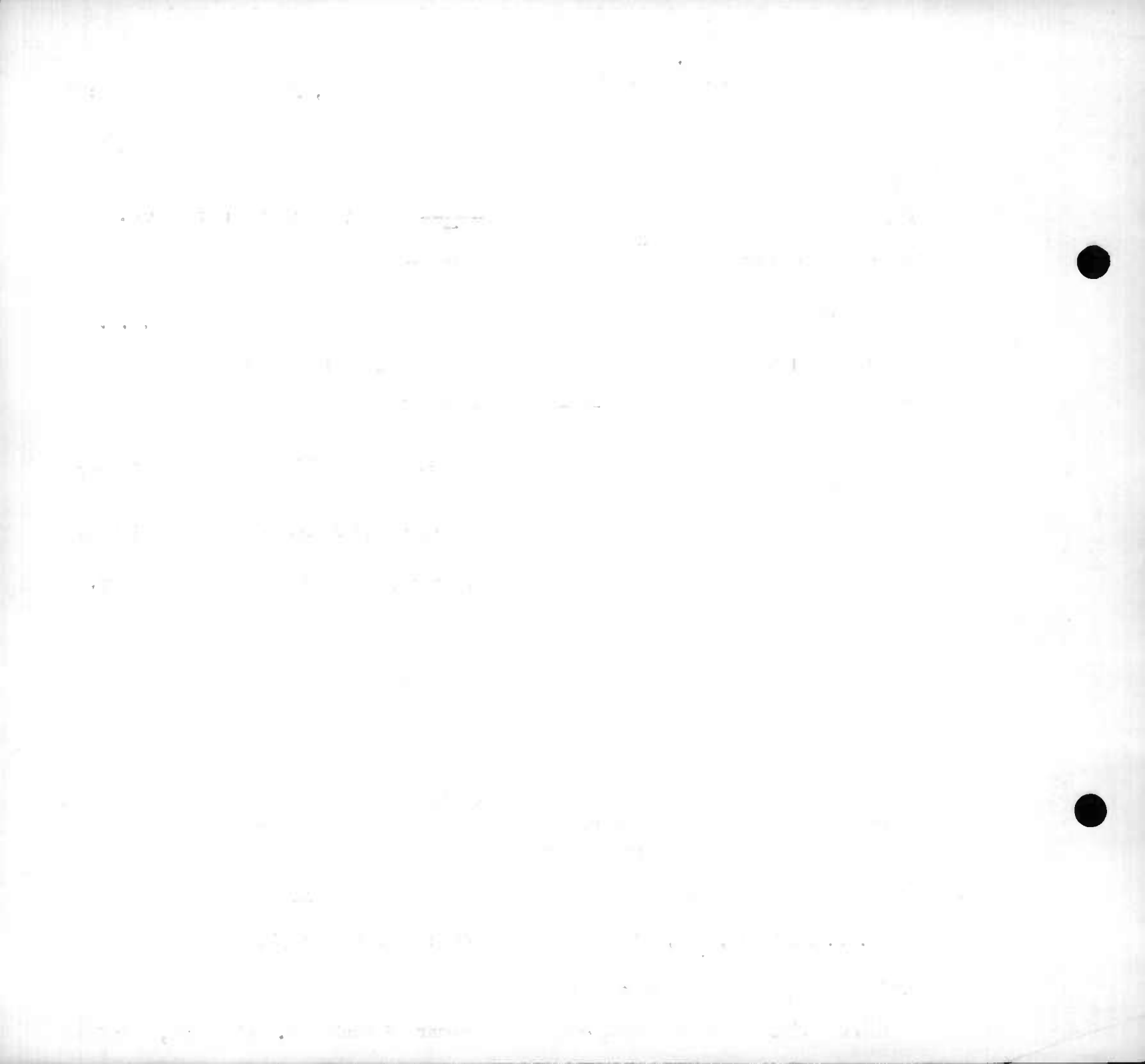
BALTIMORE CITY HEALTH DEPARTMENT		70 5777		REG. NO. 70 5777	
BIRTH NO. 70 5777		NAME OF DECEASED M. Nancy Smith		DATE AND HOUR OF DEATH 6/5/70 2:40 A.M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Middtown Home, Inc. 808 St. Paul Street Baltimore, Maryland		A. STATE Maryland B. COUNTY Prince George 66-00	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/21/86 85 9. AGE (In years lost birthday) 82 84	
Housewife				11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C. H. Cawthorne		14. MOTHER'S MAIDEN NAME Cora ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 578-10-7585D		17. INFORMANT Mr. Jeter Smith, 4113 Tennyson Rd. Hyattsville Md.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4124 I		Cardio-Respiratory Failure			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Congestive Heart Failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Arteriosclerosis C.U.D.			
		(C) Chn. Brain Syndrome			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Apr 10 1962 to June 5 1970, that (I) (we) last saw the deceased alive on Jan 5 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Willard Appleford		6/5/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Willard Appleford		6615 Hunterston Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/9/70.		Antioch Church Cemetery	
				Farmville, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 8 1970		Robert E. Taylor, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5778</u>
BIRTH NO. <u>70 5778</u>		V.		
1. NAME OF DECEASED (Type or Print) <u>DOROTHY PAXTON</u>		2. DATE AND HOUR OF DEATH <u>June 4, 1970</u> <u>8:00 p</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2734</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>5617 BELLE VISTA AVE.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-24</u>	9. AGE (In years last birthday) <u>46</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>RUFUS ADKINS</u>		14. MOTHER'S MAIDEN NAME <u>HELEN WILLIAMS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-10-0756</u>		17. INFORMANT <u>Mr William E Paxton</u>
		ADDRESS <u>Same</u>		
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY INSUFFICIENCY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PROBABLE TUMOR EMBOLI</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>METASTATIC BREAST CARCINOMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mp.</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>201</u> (this hospital) attended the deceased from <u>May 29</u> 19 <u>70</u> to <u>June 4</u> 19 <u>70</u> and that (I) <u>202</u> last saw the deceased alive on <u>June 4</u> 19 <u>70</u> and that in (my) <u>203</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>204</u> (did) <u>205</u> view the body after death.				
23A. SIGNATURE <u>N. F. Adkinson, Jr., MD</u>				23B. DATE SIGNED <u>6/4/70</u>
23C. PHYSICIAN'S NAME (Type) <u>N. F. ADKINSON, JR., MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/8/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	24D. LOCATION (City, town, or county) (State) <u>Rock Hall Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Gable, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Maryland</u>		



D-162

70 5779

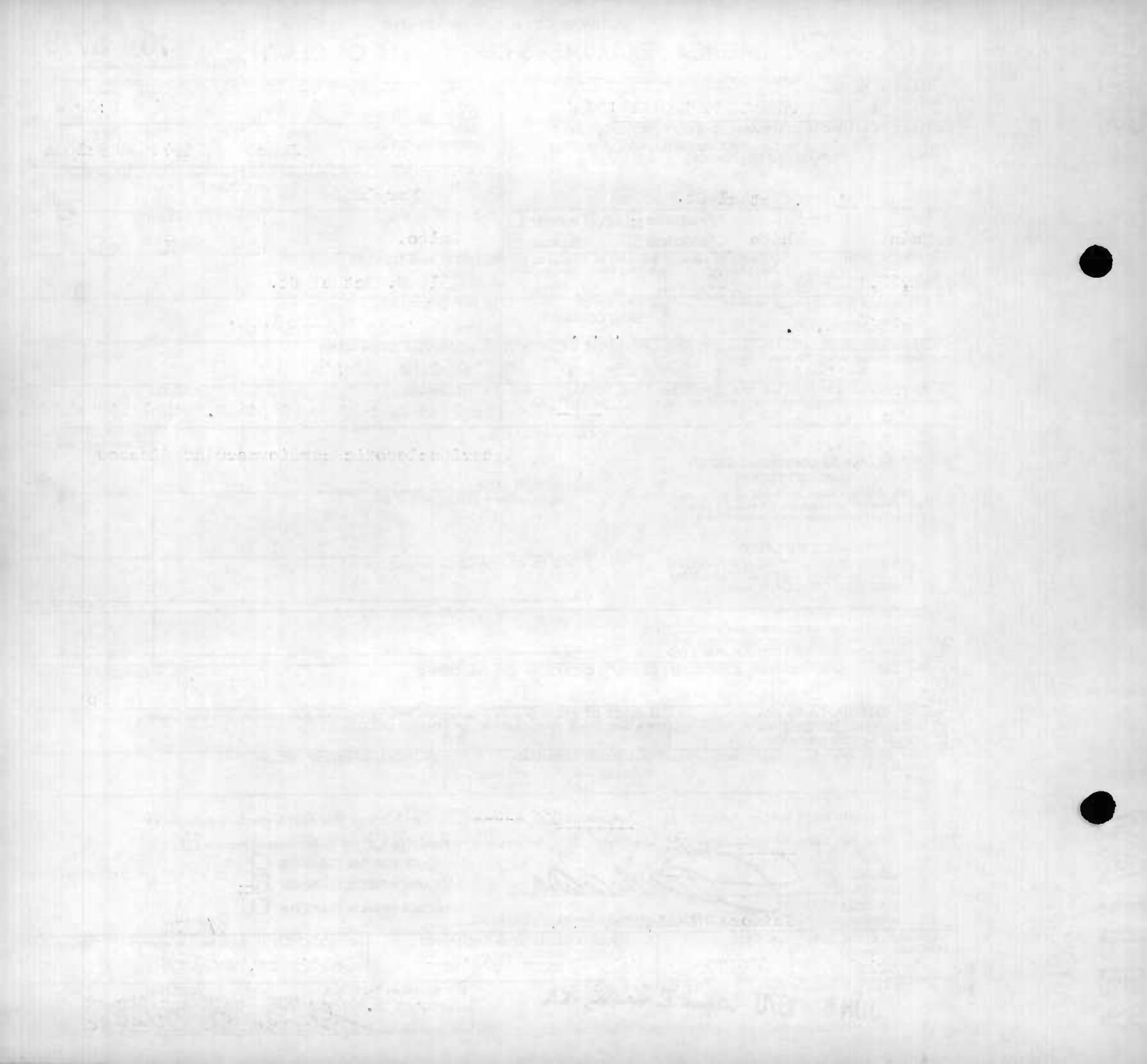
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5779

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANK THOMAS DOBROCHOWSKI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>6 6 70</b>		3. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>6</b> Year <b>1970</b>		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>516 S. Bethel St.</b>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>203</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb, 22, 1902</b>		10. AGE (In years lost birthday) <b>68</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank Tomas Dobrochowski</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Longshoreman</b>		15. MOTHER'S MAIDEN NAME <b>Caroline Rusin</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-10-1969</b>	
18. INFORMANT <b>Pauline Dobrochowski</b>		ADDRESS <b>516 S. Bethel Street</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>6/6/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/6/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/9/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Isidore E. Mihalakis, M.D.</b>		25C. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 South Ann Street</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 5780

BIRTH NO.

70 5780

1. NAME OF DECEASED  
(Type or Print)

BAUMOHL, LOUIS H.

2. DATE AND HOUR OF DEATH

6-4-70

11 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL of BALTO.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

Balt Co.

53-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

Old Ct. Rd #8

BOX #321

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/12/12

9. AGE (in years last birthday)

58

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETAIL

10B. KIND OF BUSINESS OR INDUSTRY

MERCHANT

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

MARTIN BAUMOHL

14. MOTHER'S MAIDEN NAME

ESTHER COHEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. RUTH BAUMOHL, BOX 321 OLD COURT RD. #8

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

UREMIA

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) HYPERTENSION

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

months

Years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

DIABETES MELLITUS, CVA.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 5-31-70 19 to 6-4-70 19 that (1) (we) lost saw the deceased alive on 6-4-70 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. G. DENHEIMER M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6-4-70

23C. PHYSICIAN'S NAME (Type)

M. G. DENHEIMER, M.D.

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6-5-70

24C. NAME of CEMETERY or CREMATORY

BALTIMORE HEBREW

24D. LOCATION (City, town, or county) (State)

REISTERSTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JUN 8 1970

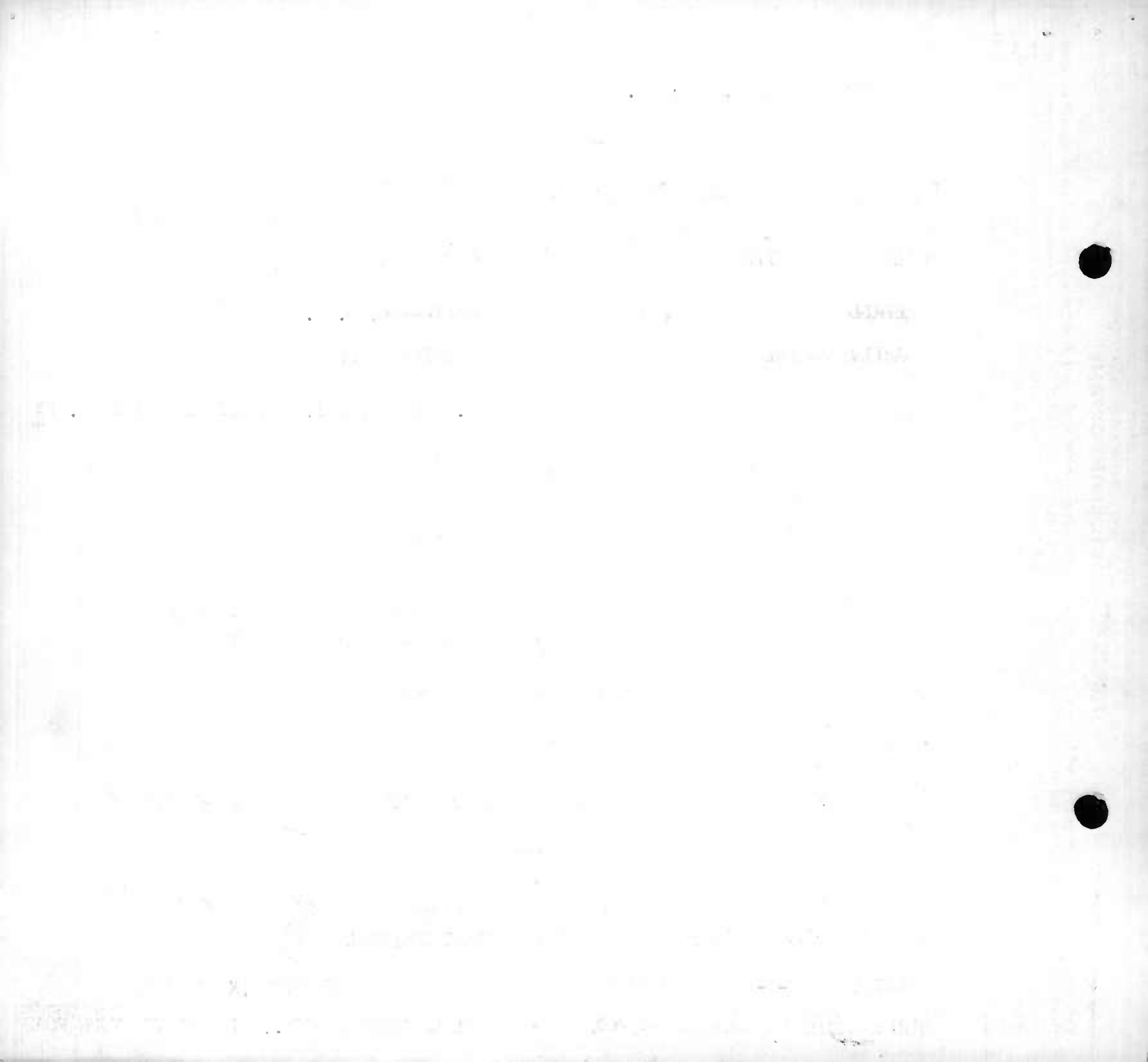
25B. NAME OF REGISTRAR

Robert E. Gaber, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

70 5781

## CERTIFICATE OF DEATH

REG. NO. 70 5781

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GOLDIE WOLFE</b>		2. DATE AND HOUR OF DEATH <b>JUNE 3, 1970</b>   <b>8 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1537</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>3306 POWHATAN AVENUE</b> <b>00</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3306 POWHATAN AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JAN. 10, 1882</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>LOUIS GORDON</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-24-0425</b>		17. INFORMANT <b>MRS. VELLA SILVER, 7000 PARK HEIGHTS AVENUE</b>
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>A.S. C.V. Disease</b>			CAUSE OF DEATH <b>Cardiac Arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A.S. C.V. Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 24 1970</b> to <b>June 3 1970</b> , that (I) (we) last saw the deceased alive on <b>June 3 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum</b>				23B. DATE SIGNED <b>6/4/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM</b>				23D. ADDRESS <b>1115 N. CALVERT STREET</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-5-70</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-01 BY 60322

REASON FOR DECLASSIFICATION

1.5 EXEMPT FROM GDS

EXEMPT

10-10-01 10-10-01 10-10-01 10-10-01 10-10-01

THIS DOCUMENT IS UNCLASSIFIED

DATE 10-10-01 BY 60322

REASON FOR DECLASSIFICATION

DATE 10-10-01 BY 60322

DATE 10-10-01 BY 60322

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">70 5782</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">70 5782</span>	
1. NAME OF DECEASED (Type or Print) <b>Emanuel Kessler</b>				2. DATE AND HOUR OF DEATH <b>6/4/70 1:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>42 Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balt Co.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hospital</b>				C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>8035 Woodgate Ct</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/15/1911</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>GROCERY STORE</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>ISAAC KESSLER</b>				14. MOTHER'S MAIDEN NAME <b>BELLA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS. SYLVIA KESSLER, 8035 WOODGATE COURT</b>	
18. <b>4/10/9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>9 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____		that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jerome Coller</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6-4-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JEROME COLLER</b>				23D. ADDRESS <b>2217 SOUTH ROAD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-4-70</b>		24C. NAME of CEMETERY or CREMATORY <b>PETACH TIKVAH</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 3010 REISTERSTOWN ROAD</b>			

10/12/12  
25  
10/12/12  
25

25  
X  
W  
M

10/12/12  
25  
10/12/12  
25

James D. [unclear]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5783</span>
BIRTH NO. <span style="font-size: 1.5em;">70 5783</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">COHEN, ALAN LOUIS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3 JUNE 70 3:15 P.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">HASINAI HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALTO.</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>		6. RACE <span style="font-size: 1.2em;">WHITE</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <span style="font-size: 1.2em;">NOV. 12, 1904</span>		9. AGE (in years last birthday) <span style="font-size: 1.2em;">65</span>		10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">PROPRIETOR</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">ADVERTISING-PROMOTION</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">N.Y.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">HARRIS COHEN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FANNIE ?</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-20-4035</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS. TILLIE COHEN, 3909 SEVEN MILE LANE</span>
18. <span style="font-size: 1.5em;">450 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.5em;">MASSIVE PULMONARY EMBOLUS</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">NONE</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2 June</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">3 June</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3 June</span> 19 <span style="font-size: 1.2em;">70</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Michael Levin, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">June 3, '70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MICHAEL L. LEVIN, MD</span>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
<span style="font-size: 1.2em;">BURIAL</span>		<span style="font-size: 1.2em;">6-5-70</span>		<span style="font-size: 1.2em;">BETH EL MEMORIAL PARK</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>

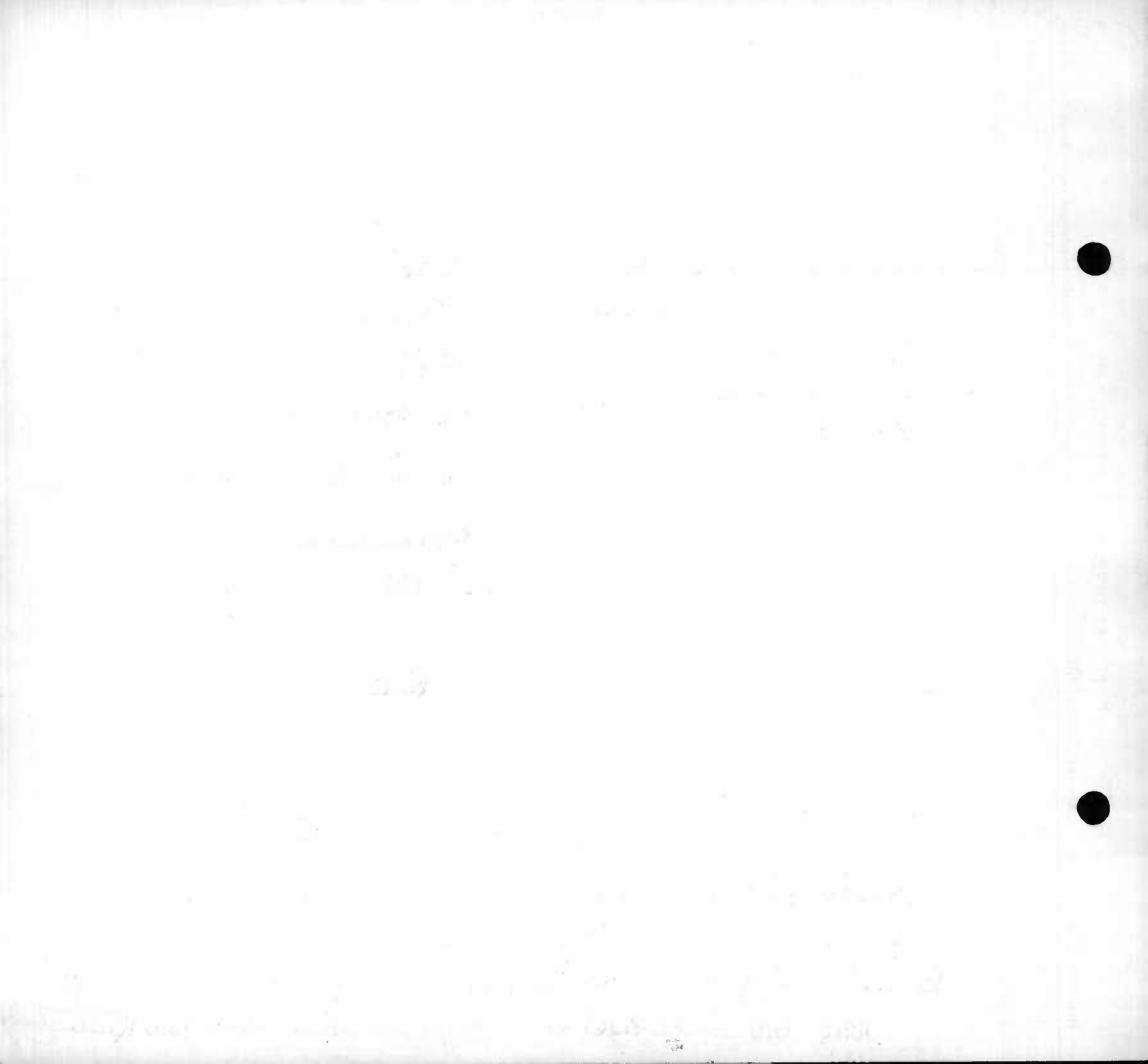




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

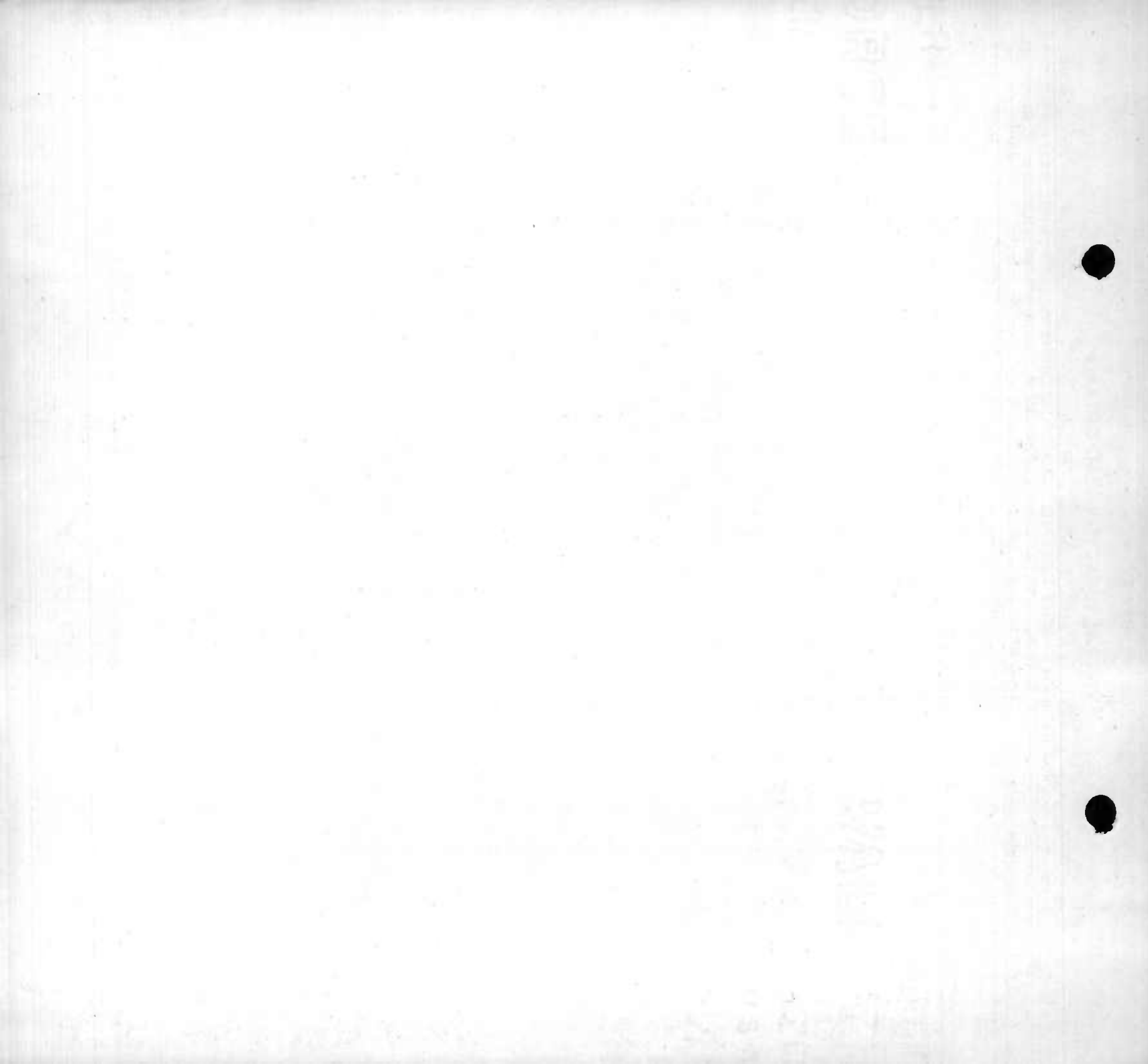
F-300 1		BALTIMORE CITY HEALTH DEPARTMENT		70 5784		CERTIFICATE OF DEATH		REG. NO. 70 5784	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSE FEIT</b>				2. DATE AND HOUR OF DEATH <b>JUNE 3, 1970 12:37 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/17/91</b>		9. AGE (In years last birthday) <b>79</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>David</b>		14. MOTHER'S MAIDEN NAME <b>Ruffner</b>		17. INFORMANT <b>Hoagland</b>		ADDRESS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.							
18. <b>412.2 I</b>		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Vascular Accident</b>						<b>3 days</b>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b>							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(C) <b>ASCVD</b>							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 31</b> 1970 to <b>JUNE 3</b> 1970 that (I) (we) last saw the deceased alive on <b>JUNE 3</b> 1970 and that I (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Victor Borden MD</b>		23B. DATE SIGNED <b>6/3/70</b>		23C. PHYSICIAN'S NAME (Type) <b>VICTOR BORDEN M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>6/3/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Boyle Zedek</b>		24D. LOCATION (City, town, or county) <b>Balto</b>		(State) <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, MD</b>		25C. FUNERAL DIRECTOR <b>Sylvester &amp; Son</b>		ADDRESS <b>2501 9610 Reisterstown Rd</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

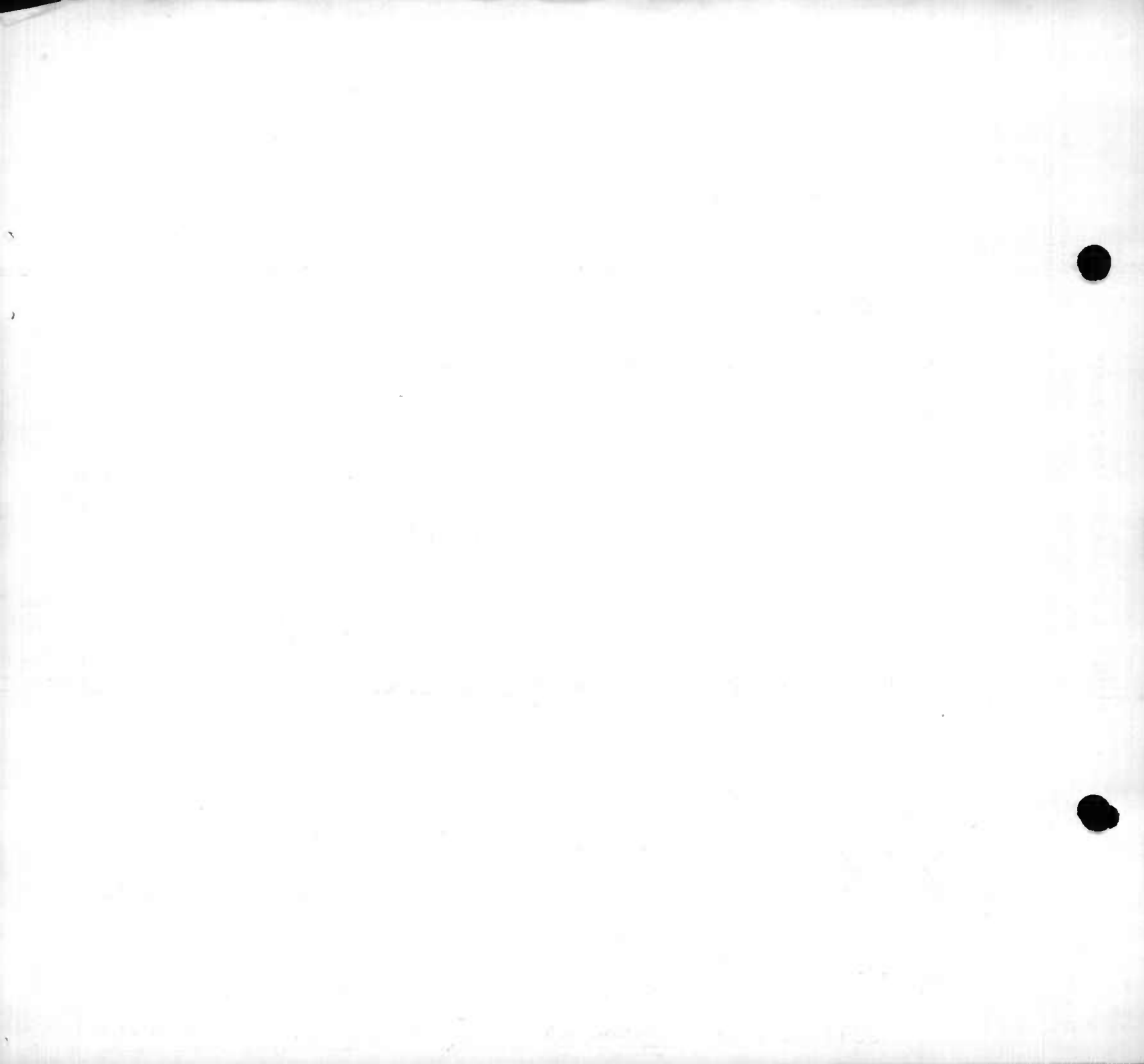
Baltimore City Health Department				REG. NO.	
70 5785		70 5785			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GORDON Samuel		May 24, 1970 5:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
		Maryland		1901	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Bolton Hill Nursing & Convalescent Ctr.		1508 West Baltimore Street			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-25-01	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Seaman		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 559-01-9041		17. INFORMANT ADDRESS	
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bacterial Pneumonia (B) advanced Cerebral Arteriosclerosis (C) A.S.C.V.D. status post MI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Elegance Obesity Benign Prostatic Hypertrophy				years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 18 1970 to May 24 1970, that (I) (we) lost saw the deceased alive on May 23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H. Rheinstein, MD		23B. DATE SIGNED May 25, 1970			
23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN, MD		23D. ADDRESS 1111 Park Avenue Baltimore, Maryland 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 6-6-70	24C. NAME OF CEMETERY or CREMATORY MT. CALVARY	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970	25B. NAME OF REGISTRAR John E. Taylor, Jr.	25C. FUNERAL DIRECTOR W. J. Tickner & Son		ADDRESS North Beach	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

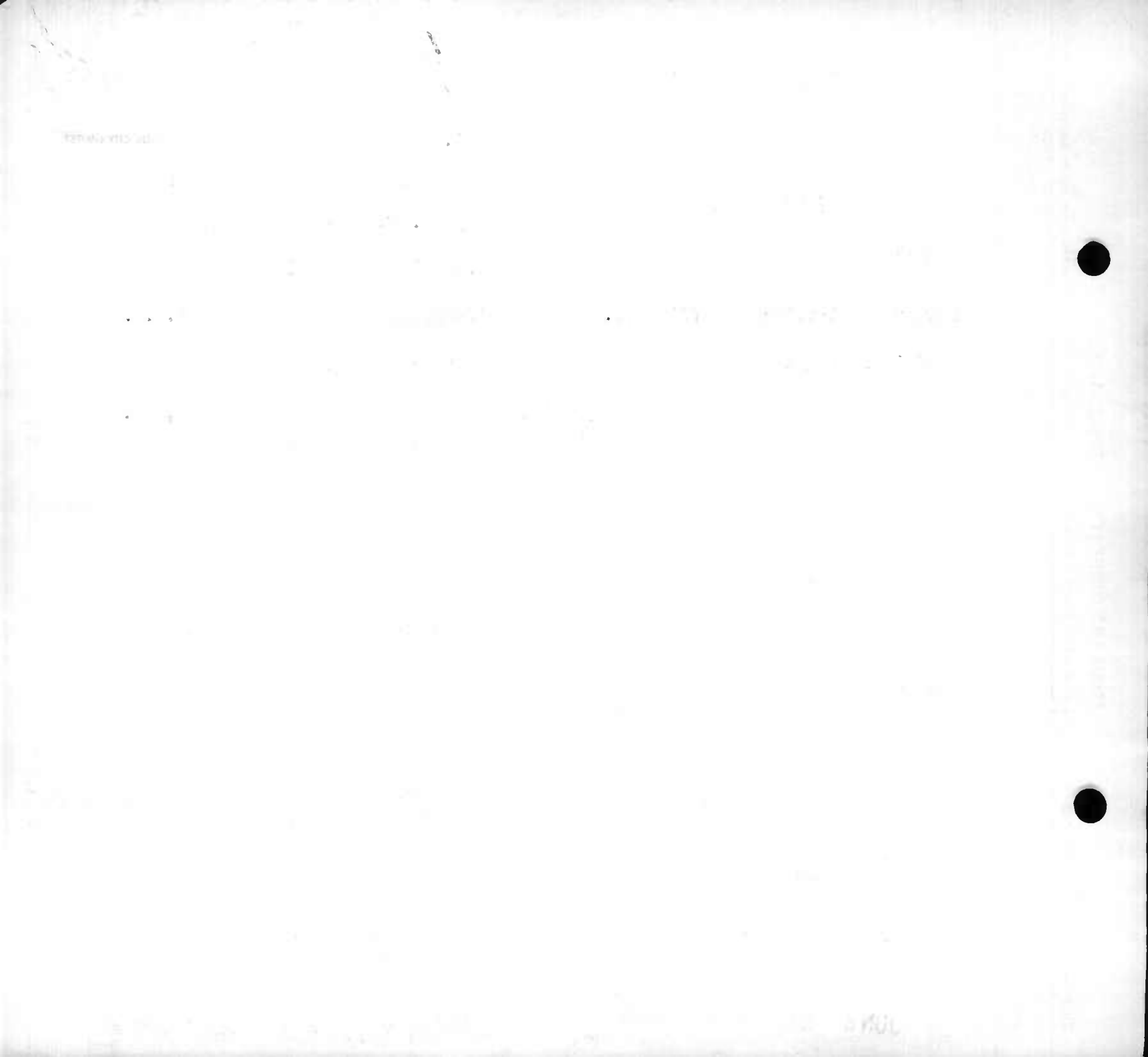
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5786</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5786</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WERNER H NOTHMAN</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JUNE 3, 1970 12:58 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">42 SINAI HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">6017 GREENSPRING</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/2/03</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">66</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">C.P.A.</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Germany</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Dr. Martin Notthman</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Selma</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-16-6931</span>			17. INFORMANT <span style="font-size: 1.2em;">Hosp chapl</span>		
18. CAUSE OF DEATH <span style="font-size: 1.2em;">410.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">CONGESTIVE HEART FAILURE @ Femoral Thrombosis Post @ A-K Amputation</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 days</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">15/26</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">@ FEMORAL THROMBOSIS</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAY 19</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">JUNE 3</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">JUNE 3</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Victor Borden M.D.</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">6/3/70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">VICTOR BORDEN M.D.</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			24B. DATE <span style="font-size: 1.2em;">6/4/70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Chesa Ahavas Chesed</span>
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Randallstown Md</span>			25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Sylvan Zeiss &amp; Son 9610 Reservoir Rd</span>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5787		REG. NO. 70 5787	
BIRTH NO.		70 5787		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>FREDERICK O. MESEKE</b>				2. DATE AND HOUR OF DEATH <b>6-5-70 9<sup>50</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>m</b>		6. RACE <b>w</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/86</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bureau Sanitation</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City Gov.</b>		9. AGE (in years last birthday) <b>83</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
13. FATHER'S NAME <b>WILLIAM MESEKE</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214 38 5257</b>		17. MOTHER'S MAIDEN NAME <b>LOUISE SCHILLER</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>4/10.9 I ACUTE MYOCARDIAL INFARCTION</b>				19. INFORMANT <b>FRANCES JOHANNIS MILLERSVILLE, MD.</b>		ADDRESS	
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>6-5-70</b> 19 <b>6-5</b> 19 <b>70</b> that <del>he</del> (we) last saw the deceased alive on <b>6-5-70</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.				20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23A. SIGNATURE <b>Bayani C. Manalo, M.D.</b>				23B. DATE SIGNED <b>6-6-70</b>		23C. PHYSICIAN'S NAME (Type) <b>BAYANI C. MANALO</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>6-9-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Louder Park</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>McCully</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				25D. ADDRESS <b>130 E Fort Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

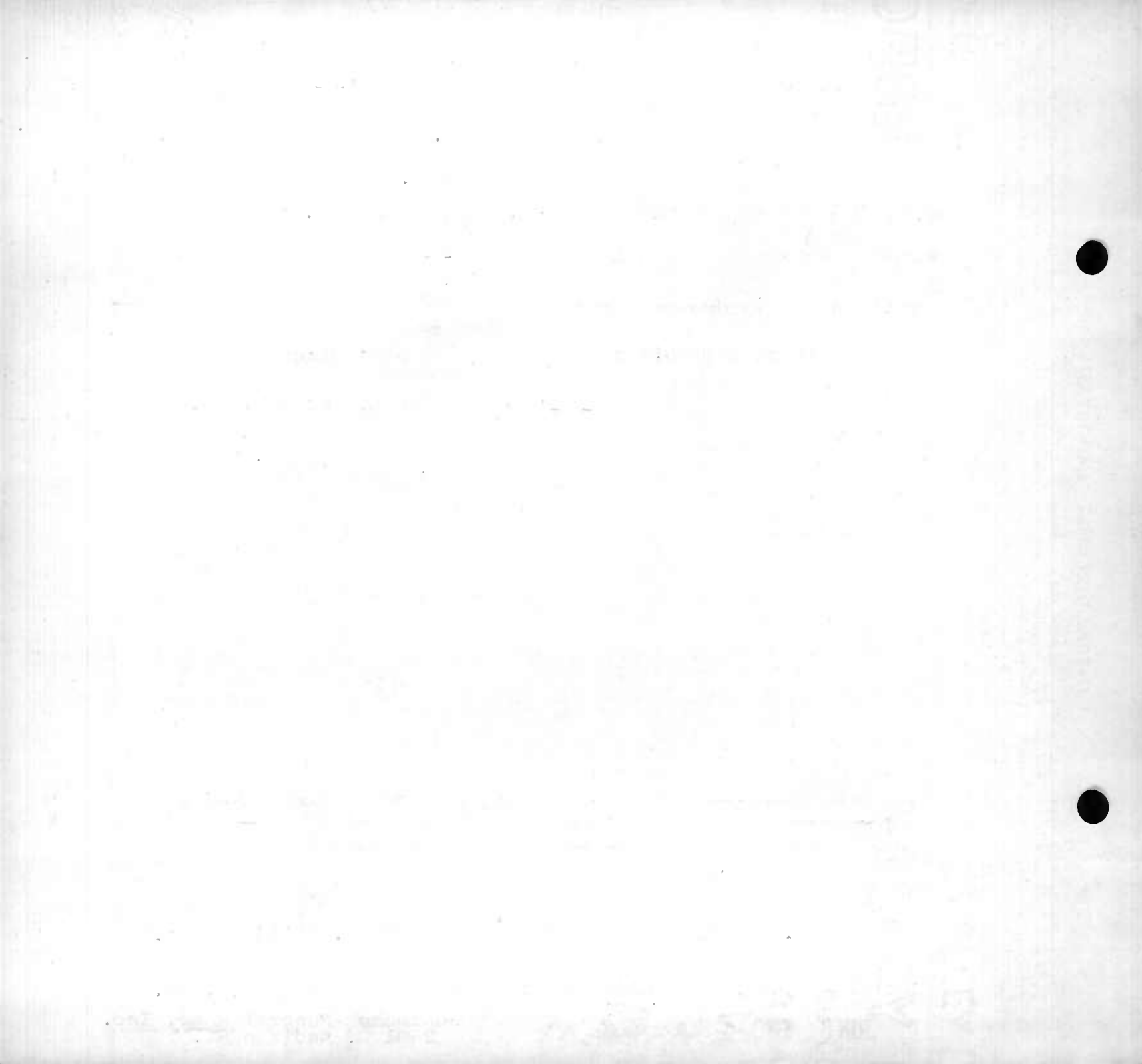
BALTIMORE CITY HEALTH DEPARTMENT									
70 5788					CERTIFICATE OF DEATH		REG. NO. 70 5788		
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <b>GEORGE FRANCIS MYERS</b>				
2. DATE AND HOUR OF DEATH <b>6/5/70 1 3 P.M.</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. Md. BALT, Md.</b>					A. STATE <b>MD.</b> B. COUNTY <b>BALT Co.</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <b>BALT</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <b>6601 RICHARDSON Rd.</b>					21207 <b>Balto. Md.</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-19</b>	9. AGE (in years last birthday) <b>50</b>	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TECHNICIAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>NASA</b>			11. BIRTHPLACE (State or foreign country) <b>Reading Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>HUBERT MYERS</b>			14. MOTHER'S MAIDEN NAME <b>ANNA SCHMIDT Scrimfrand</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes UN 2</b>			16. SOCIAL SECURITY NO. <b>161.149408</b>			17. INFORMANT <b>WIFE</b> ADDRESS <b>SAME</b>			
18. <b>4/10/9 I</b> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ANT-2AT m8</b>				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(B) DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					(C) DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>yes</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?			22. I certify that (I) (this hospital) attended the deceased from <b>6/5</b> 19 <b>70</b> to <b>6/5</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/5</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <b>Howard Wallach, MD</b>			23B. DATE SIGNED <b>6/5/70</b>			23C. PHYSICIAN'S NAME (Type) <b>HOWARD WALLACH MD</b>			
23D. ADDRESS <b>UNIV. Md. Balt. Md.</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6/9/70</b>			
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>			24D. LOCATION (City, town, or county) (State) <b>Woodlawn Baltimore Maryland</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR <b>J.T. Stansbury, Sr.</b>			ADDRESS <b>6411 Windsor Mill Rd.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5789</b>
<div style="display: flex; justify-content: space-between;"> <span><b>70 5789</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Irene Lottie Fairbanks</b>		
2. DATE AND HOUR OF DEATH <b>6-3-70 9:00 A.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Bolton Hill Nursing &amp; Convalescent Center</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2643</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3546 Dudley Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-1896</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Edgewood Arsenal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Albert Hoffheiser</b>		14. MOTHER'S MAIDEN NAME <b>Anna Baker</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-0807</b>		17. INFORMANT <b>Charles L. Foreman, son, above</b>
18. <b>4123 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov 12 1945</b> to <b>June 3 1970</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>May 29 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.				
23A. SIGNATURE <b>Stanley Felsenberg</b>		23B. DATE SIGNED <b>6/5/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Stanley Felsenberg</b>		23D. ADDRESS <b>222 E. Baltimore St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/6/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>
				ADDRESS <b>2601 E. Madison St.</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

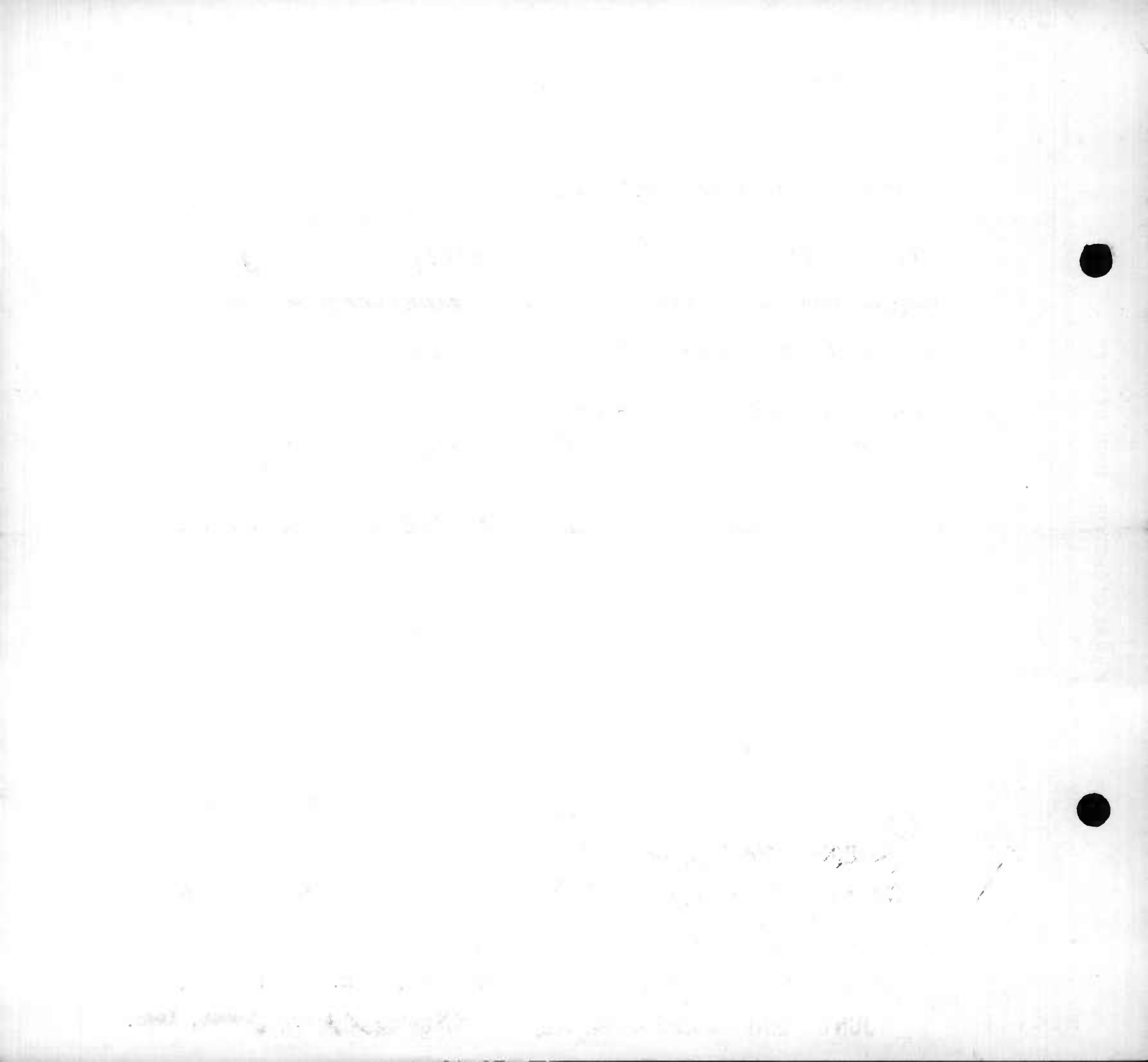
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5790</b>
BIRTH NO. <b>70 5790</b>		CERTIFICATE OF DEATH		June 3, 1970
1. NAME OF DECEASED (Type or Print) <b>Michael Louis VOTTA</b>		2. DATE AND HOUR OF DEATH <b>6-3-70 10:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md., 21213</b> B. COUNTY <b>2633</b>		
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>3022 Chesterfield Ave.</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/89</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Frank S. Votta</b>		
14. MOTHER'S MAIDEN NAME <b>Susanna Cuneo</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-28-7199A</b>		
16. SOCIAL SECURITY NO. <b>212-28-7199A</b>		17. INFORMANT <b>Alice Gossage Votta, wife, above</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Terminal stage of Ca. prostate</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>05-10-1970</b> to <b>6-3-1970</b> that (I) (we) last saw the deceased alive on <b>6-3-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Butin Srisumrod M.D.</b>		23B. DATE SIGNED <b>6-3-1970</b>		23C. PHYSICIAN'S NAME (Type) <b>BUTIN SRISUMROD M.D.</b>
23D. ADDRESS <b>Mercy Hosp.</b>		23E. SIGNATURE <b>Robert E. Tabor, M.D.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/6/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		

Called Mercy Hospital and obtained correct  
date of death 6-12-70 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5791</u>
BIRTH NO. <u>70 5791</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>JOSEPH F. NAWROZKI JR.</u>		2. DATE AND HOUR OF DEATH <u>6/3/70</u> <u>6:10</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> J B. COUNTY <u>841</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE 13</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>3209 CLIFTMONT AVENUE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/03/96</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn New York</u>
13. FATHER'S NAME <u>JOSEPH F NAWROZKI SR.</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> Navy <u>WW1</u>		16. SOCIAL SECURITY NO. <u>215-30-6124A</u>		17. INFORMANT <u>MRS HONORA NAWROZKI</u>
				ADDRESS <u>3209 CLIFTMONT AVE</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>162-1 I</u> <u>UNDESPREAD MALIGNANT METASTASIS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF THE LUNG</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>6/1</u> 19 <u>70</u> to <u>6/3</u> 19 <u>70</u> that <u>(I)</u> (we) last saw the deceased alive on <u>6/3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Anne L. Leddy M.D.</u>				23B. DATE SIGNED <u>6/3/70</u>
23C. PHYSICIAN'S NAME (Type) <u>Anne L. Leddy M.D.</u>		23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>6/8/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cem.</u>		24D. LOCATION City, town, or county (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>
				ADDRESS <u>3331 Brehms Lane</u>

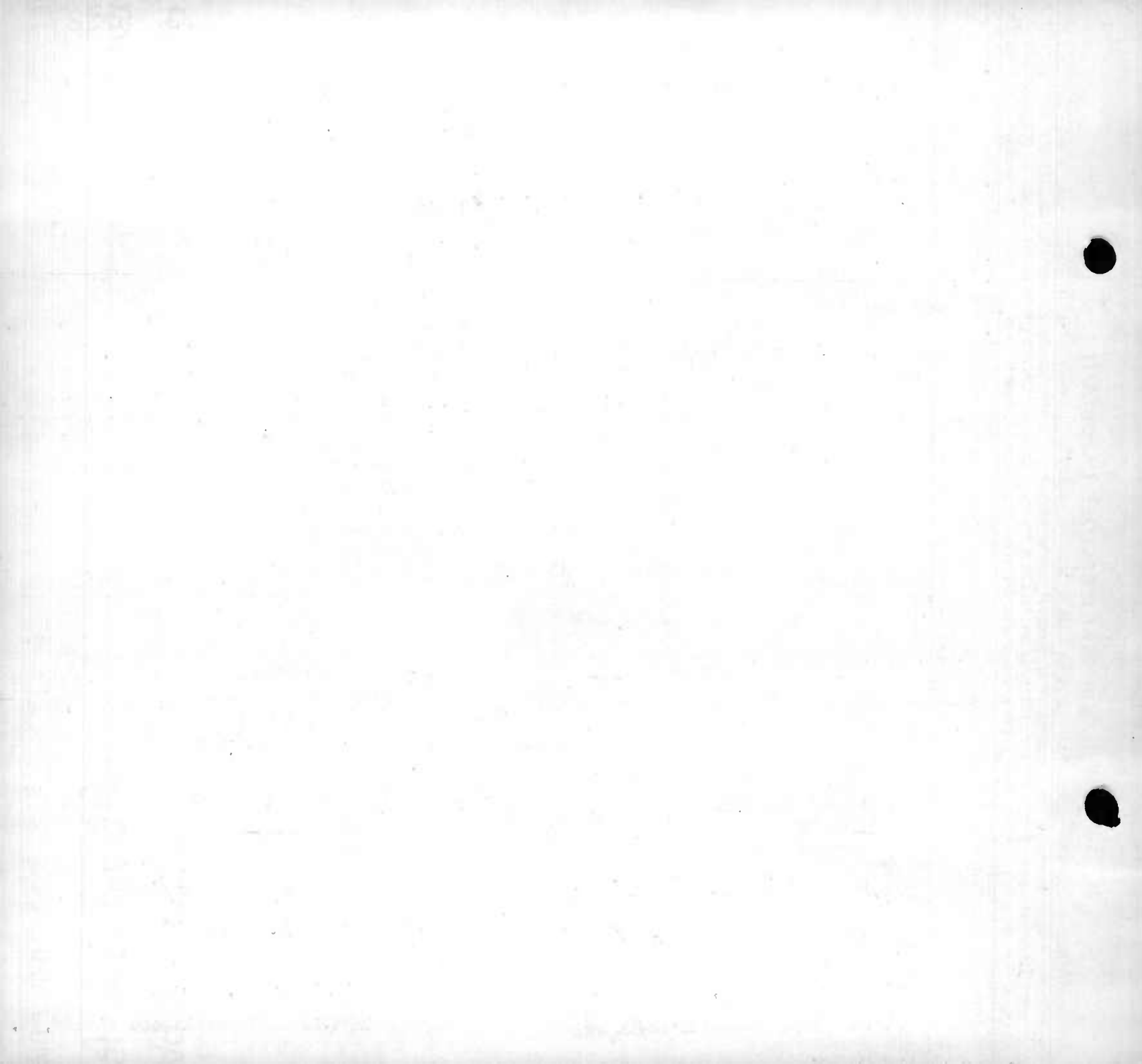




FUNERAL DIRECTOR: IMPORTANT

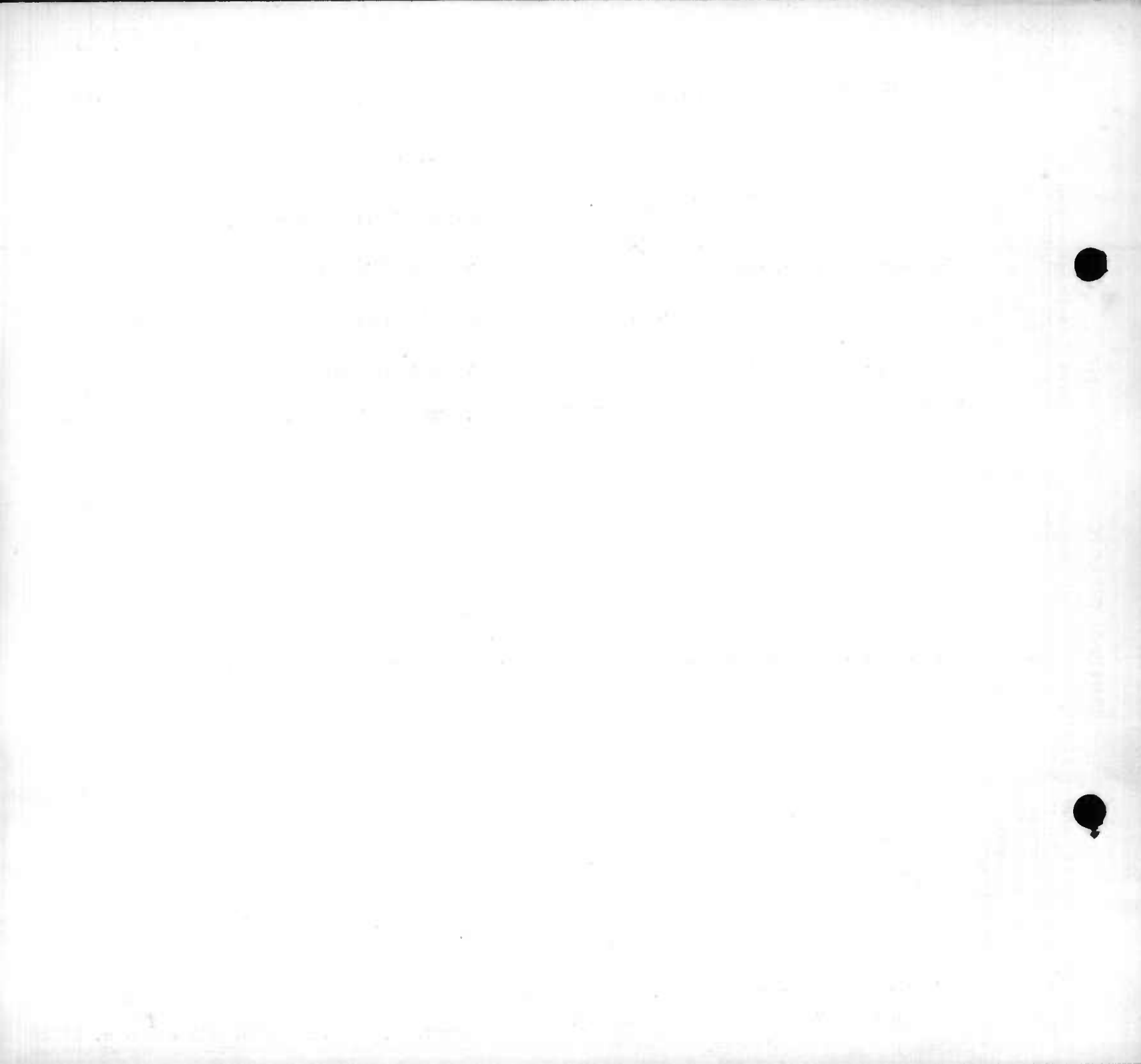
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5792		REG. NO. 70 5792	
1. NAME OF DECEASED (Type or Print) <b>ETHEL ELIZABETH THOMASON</b>				2. DATE AND HOUR OF DEATH <b>6/3/70</b> <b>4 P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPAS HOSPITAL BALTIMORE</b>				A. STATE <b>MD</b>		B. COUNTY <b>V-43</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>FALLS CHURCH, VA</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
STREET AND NUMBER <b>VIRGINIA</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/22</b>	9. AGE (In years last birthday) <b>48</b>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>	
13. FATHER'S NAME <b>WILLIAM OVERBOUGH</b>				14. MOTHER'S MAIDEN NAME <b>LORETTA WYMKOP</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>017-16-9537</b>		17. INFORMANT ADDRESS <b>UPHS HOSPITAL BEHIND ROOM</b>	
18. <b>1929 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASPIRATION</b> <b>ASTROCYTOMA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>4 DAYS</b> <b>~ YEAR</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>—</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/29/70</b> 19 to <b>6/3</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>6/3/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Stephen C. Schimpff MD</b>				23B. DATE SIGNED <b>6/3/70</b>		23C. PHYSICIAN'S NAME (Type) <b>STEPHEN C. SCHIMPF</b>	
23D. ADDRESS <b>USPAS HOSPITAL, BALTIMORE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 6, 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>East Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Williamstown, Massachusetts</b>	
25A. DATE REC'D BY HEALTH DEPT <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Money &amp; King Vienna Funeral Home Vienna, Va.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5793</u>	
70 5793				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type on Page)		2. DATE AND HOUR OF DEATH	
		Bernice Lorraine Malik		6/4/70 7:45 pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.				A. STATE Maryland	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 407 N. Highland Ave.	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1915	9. AGE (in years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Joseph Bolyard				12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME E. Rhuea McGee	
16. SOCIAL SECURITY NO. 181-12-5803				17. INFORMANT Mr. Frank Malik, Jr. 407 N. Highland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Possible Acute myocardial infarction, diaphragmatic				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Possible diffuse cerebral arteriosclerosis & acute & old CVA (C) Diabetes mellitus					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month, Day, Year, Hour) I APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 5 1970 to June 4 1970 that (I) (we) last saw the deceased alive on June 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Hippolito, M.D.				23B. DATE SIGNED 6/4/70	
23C. PHYSICIAN'S NAME (Type) A. Hippolito, M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-9-1970		Mt. Zion Cemetery	
				24D. LOCATION (City, town, or county) (State) Fellowsville, West Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70-10029 70 5794				BALTIMORE CITY HEALTH DEPT.		REG. NO. 70 5794	
1. NAME OF DECEASED (Type or Print) <b>BABY BOY KOHLES</b>				2. DATE AND HOUR OF DEATH <b>6/3/70 5:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2737</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>MAY 30, 1970</b>		9. AGE (in years last birthday) <b>4 DAYS</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
13. FATHER'S NAME <b>J. RICHARD KOHLES</b>				14. MOTHER'S MAIDEN NAME <b>MARYANN DUFFY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>J. RICHARD KOHLES</b>	
18. <b>777X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity, generalized 4 days old infant.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 30 1970</b> to <b>June 3 1970</b> that (I) (we) last saw the deceased alive on <b>June 3 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Emilio P. Gonzalez, M.D.</b>				23B. DATE SIGNED <b>6/3/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Emilio P. Gonzalez, M.D.</b>	
23D. ADDRESS <b>Mercy Hosp., Balto., Md. 1102</b>				23E. FUNERAL DIRECTOR <b>Charles S. Seiler</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-4-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>4430 BELAIR RD., BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>			

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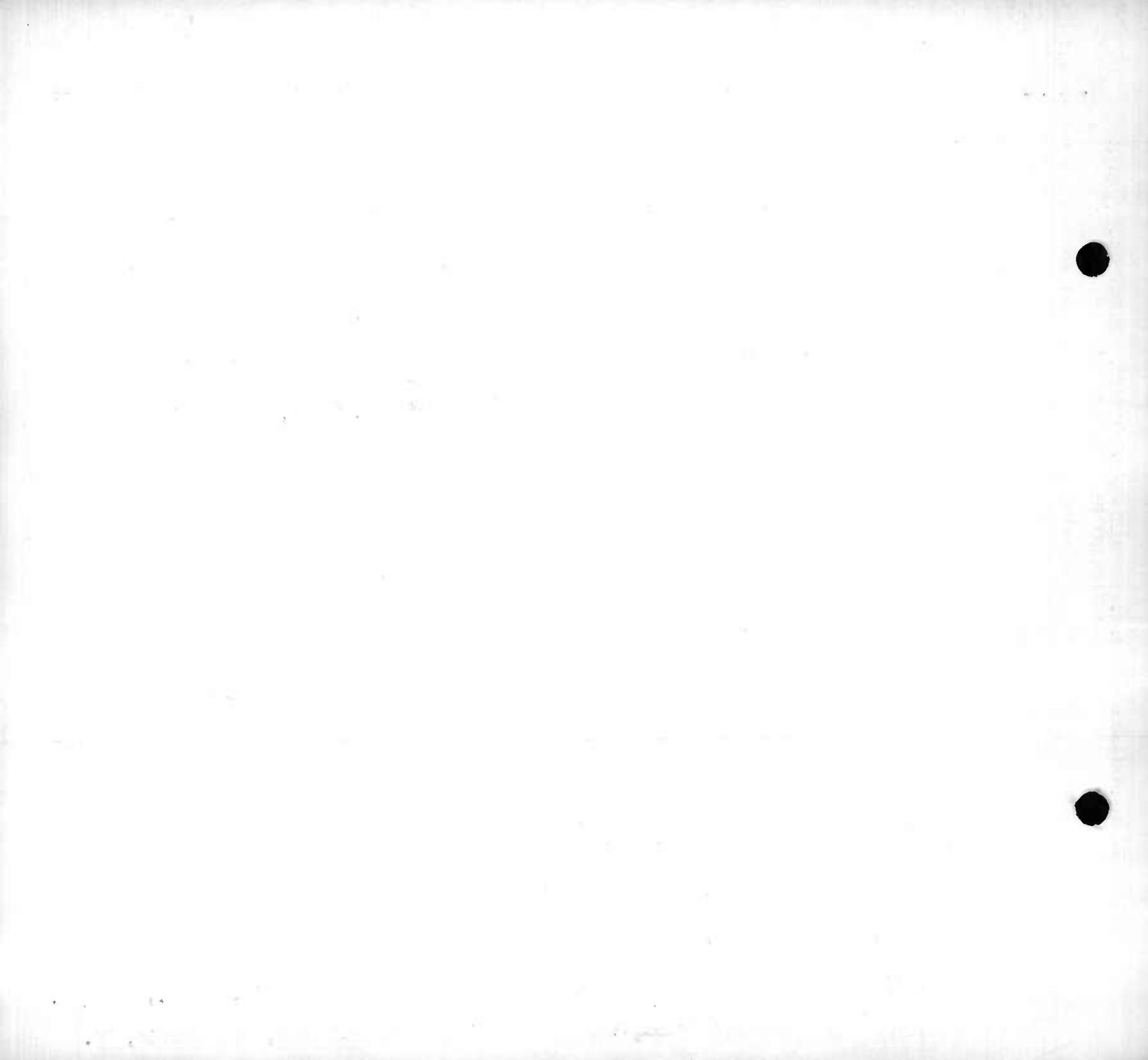
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69-14570 5795		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) TROUT, Michael		2. DATE AND HOUR OF DEATH 6/3/70 5:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland AA B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		C. CITY OR TOWN Glen Burnie	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1969	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 9 20	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Donald M. Trout		12. CITIZEN OF WHAT COUNTRY USA	
14. MOTHER'S MAIDEN NAME Shelby Wentz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Donald M. Trout, same as 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 747.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min 1 hour —	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-14 19 69 to 6-3 19 70 that (I) (we) last saw the deceased alive on 6-3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. Colin Kelly		23B. DATE SIGNED 6/3/70	
23C. PHYSICIAN'S NAME (Type) P. Colin Kelly, M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 June 70	
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. <span style="font-size: 1.5em;">70 5796</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5796</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WILLIAM C. MILLER</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JUNE 4, 1970 10:35 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTO.</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">CHURCH HOME AND HOSPITAL 35 BALTIMORE, MD.</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">8103 SHORE RD.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9.12.1892</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">77</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">UNDERGROUND CABLE SPICER</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">WASHINGTON D.C</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">AMERICA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">William C. Miller</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Katherine Lutz</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-05-5932</span>		17. INFORMANT <span style="font-size: 1.2em;">Donothy L. Myers</span>
			ADDRESS <span style="font-size: 1.2em;">8103 Shore Road</span>		
18. <span style="font-size: 1.2em;">7.12.4 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Bronchopneumonia</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">ASCVD.</span> (C) <span style="font-size: 1.2em;">Cerebral Concussion, Parkinson's Disease</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">One day</span>  <span style="font-size: 1.2em;">seven yrs.</span>  <span style="font-size: 1.2em;">7 days + 4 yrs respectively</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(if)</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">5.10</span> 1970 to <span style="font-size: 1.2em;">6.4</span> 1970 that <del>(if)</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">6.4</span> 1970 and that <del>(in my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(if)</del> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Cezar A. Lopez MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">June 4, 1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CEZAR A. LOPEZ MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">CHURCH HOME &amp; HOSP.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.2em;">6/8/70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Moreland Memorial Park</span>	
<span style="font-size: 1.2em;">Burial</span>				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John A. Morah, Inc. 3000 E. Balto. St.</span>	

CHURCH OF THE  
SACRAMENT  
H. J. BAKER

WASH. D. C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

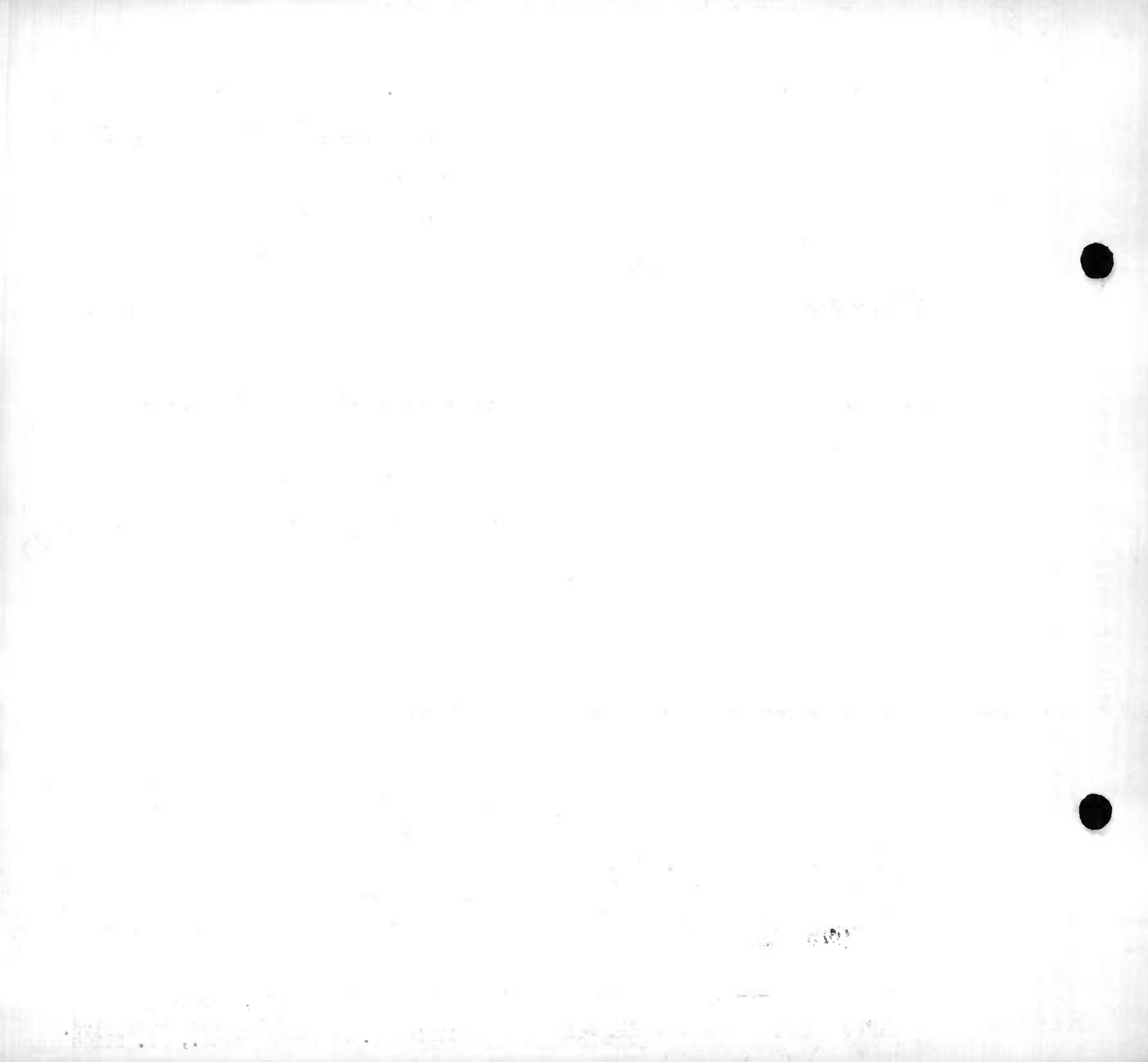
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70 5797

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 5797

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Anthony, Nick.</b>		2. DATE AND HOUR OF DEATH <b>June 5 1970 11 4 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Key Circle Hospice</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>727 South Broadway 203</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/98</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PACKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>215-01-4836</b>		17. INFORMANT ADDRESS <b>R. HAUSEN-1214 EOTAW PLACE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/12/4 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCUD-cardi's. CBS megalia</b> (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>5-10 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-26-70</b> to <b>6-5-70</b> that (I) <del>was</del> last saw the deceased alive on <b>6-4-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard R. Rigler</b>		23B. DATE SIGNED <b>6-5-70</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD R. RIGLER</b>	
23D. ADDRESS <b>1. W. OVERLEA AVE #21206</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-6-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) <b>Glen Burnie, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>William E. Johnson</b>		25D. ADDRESS <b>8521 Loch Raven Blvd. Balto., Md. 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 5798	
BIRTH NO. 70 5798		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Horace Webster</u>		2. DATE AND HOUR OF DEATH <u>6-4-70</u> <u>4:06 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE General Hos</u> <u>3001 S. HANOVER BALTO, MD 30</u>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>PASADENA</u> C. CITY OR TOWN <u>PASADENA</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>10 Spring NO 11 Dr.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-14</u>		9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Martin Co.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>DEAN WEBSTER</u>		14. MOTHER'S MAIDEN NAME <u>Helen FIGHTMEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>173-07-8711</u>		17. INFORMANT <u>my. Anna V. Webster - same name</u>	
18. <u>7119 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>ACUTE MYOCARDIAL INFARCTION</u> <u>Generalize Atherosclerosis Coronary Artery</u> <u>Helectasis Left Lower Lobe</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 2</u> 19 <u>70</u> to <u>June 4</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>June 4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Artemida Villafania</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>6-4-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ARTEMIDA-VILLAFANIA</u> DEGREE				23D. ADDRESS <u>3001 S. HANOVER ST. S. B. C. H</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION <u>Brooklyn</u>		24E. (City, town, or county)		24F. (State) <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Singleton Funeral Home / Glen Bowen, M.D.</u>	

machines

machines

172-012111 was done 8/1/1964 - 2000

Page 2

Johns Canyon Hill (cont)

Beach

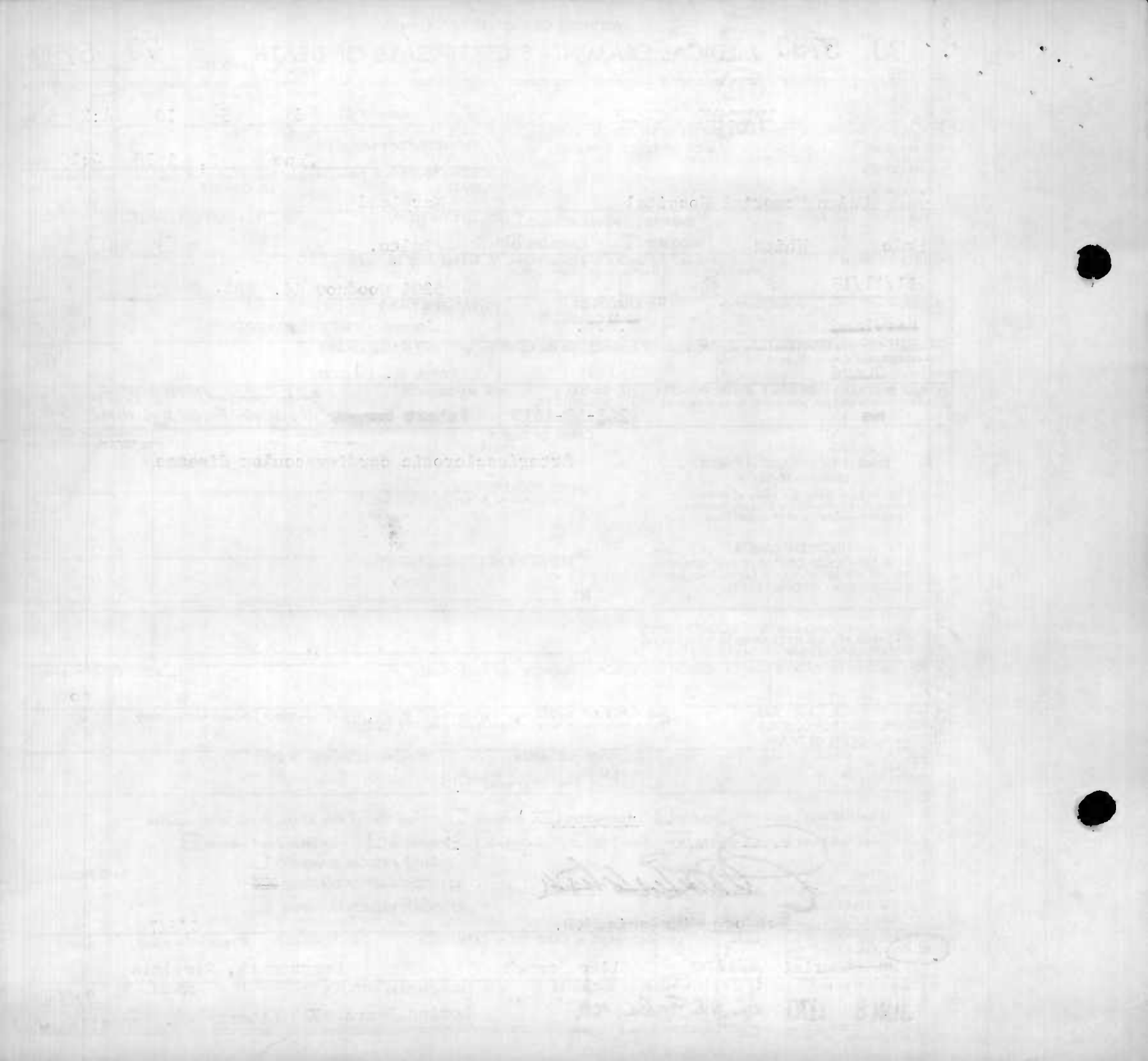
Geological Survey of the Department of the Interior

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>THURMAN BOZMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 5 70 4:20 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 5, 1970 4:20 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>11/11/13</b>		10. AGE (In years last birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		15. MOTHER'S MAIDEN NAME <b>Lena M. Clark</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>241-09-4413</b>	
18. INFORMANT <b>Robert Bunger</b>		ADDRESS <b>SPADLINE PORTSMOUTH SNELLING FUNERAL HOME VA.</b>	
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) (Of INJURY (APPROX.))		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/7/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Olive Branch</b>		24D. LOCATION (City, town, or county) (State) <b>Portsmouth, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown, MD</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 5800

BIRTH NO. New York 70 5800

1. NAME OF DECEASED  
(Type or Print)

John Thomas Rice

2. DATE AND HOUR OF DEATH

June 4, 1970

2:30

P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

NJ

C. CITY OR TOWN

Jackson

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

69 Forest Drive

5. SEX

M

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4/16/64

9. AGE (In years last birthday)

6

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jerome Rice

14. MOTHER'S MAIDEN NAME

Roberta Nisi

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

204.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Pulmonary and renal hemorrhages - days

Acute lymphocytic leukemia - years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I/this hospital) attended the deceased from Apr. 22 1970 to June 4 1970, that (I/we) last saw the deceased alive on June 4 1970 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did/did not) view the body after death.

23A. SIGNATURE

Donald E. Beaudoin MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/4/70

23C. PHYSICIAN'S NAME (Type)

Donald E. Beaudoin, SA Surg (R)

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-8-1970

24C. NAME OF CEMETERY or CREMATORY

Ocean View Cemetery

24D. LOCATION

(City, town, or county)

(State)

Staten Island, New York

25A. DATE REC'D BY HEALTH DEPT

JUN 8 1970

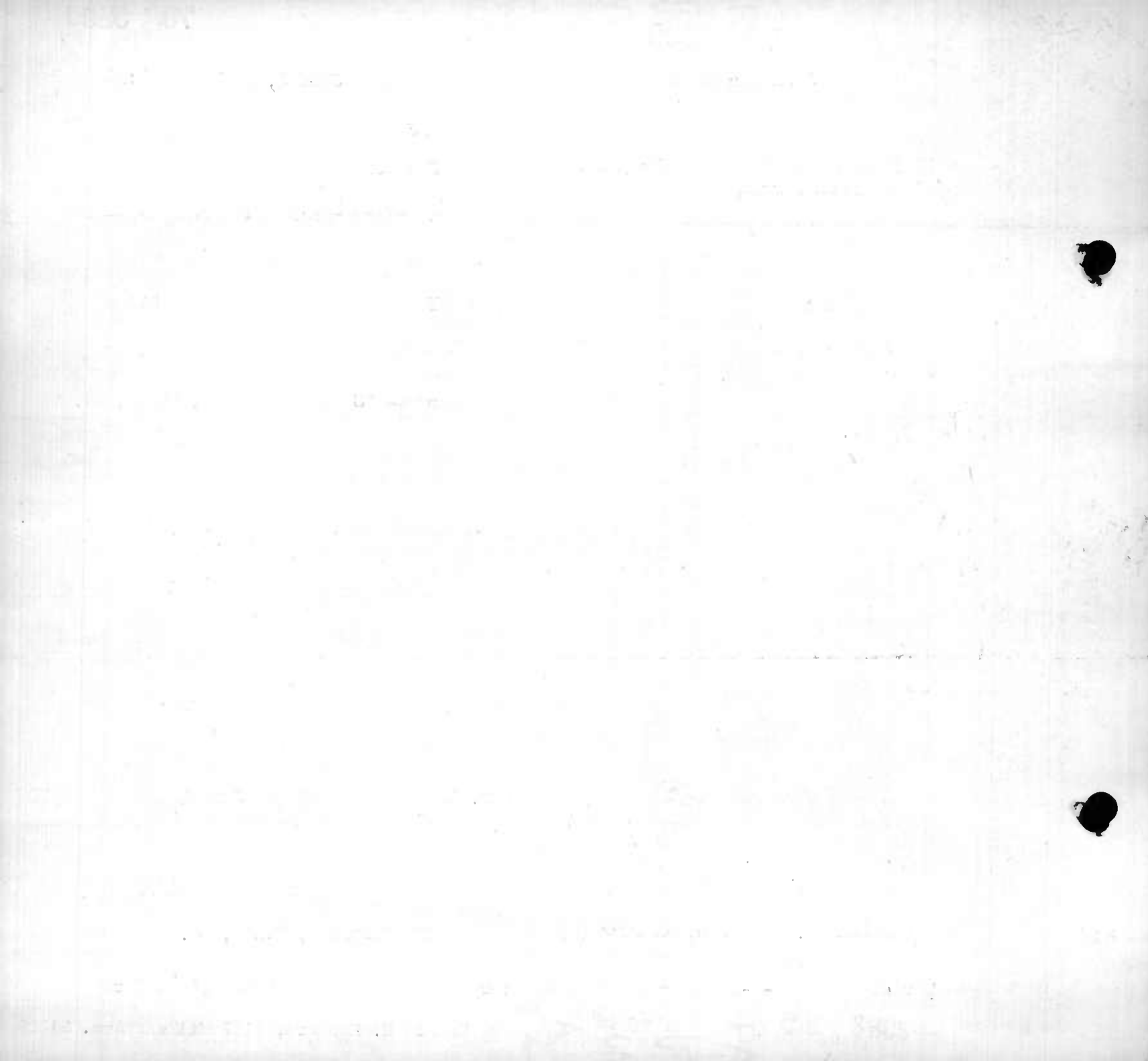
25B. NAME OF REGISTRAR

Robert E. Fisher, R.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 1669	
BIRTH NO. 70 5801		CERTIFICATE OF DEATH		70 5801	
1. NAME OF DECEASED (Type or Print) HOFFMAN, Joseph W			2. DATE AND HOUR OF DEATH 6/3/70 8:55 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  HARBOR VIEW NURSING HOME			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1004 BAUDEN COURT		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/197	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEXTON		10B. KIND OF BUSINESS OR INDUSTRY ST. STEPHENS CH.		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME George Hoffman			14. MOTHER'S MAIDEN NAME EMMA VINEYARD Both Hoffman 1004 Bauden Court		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-0040		17. INFORMANT Family - Sister ADDRESS (Wife)	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/8 1970 to 6/3 1970, that (I) (we) last saw the deceased alive on 5/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum MD			23B. DATE SIGNED 6/4/70		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 6/8/70		24C. NAME OF CEMETERY or CREMATORY Cedar Hill
24D. LOCATION (City, town, or county) (State) Baltimore			25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		
25B. NAME OF REGISTRAR Robert E. Fisher MD			25C. FUNERAL DIRECTOR McBully of 237 Patapsco Ave.		

Druidon

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5802	
BIRTH NO. 70 5802		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH JUNE 5, 1970 9:25 P.M.	
1. NAME OF DECEASED (Type or Print) RICHARDSON, HARRY ADAM, SR.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 2864 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4611 MANORDENE ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10 20 87	9. AGE (In years last birthday) 82	11. BIRTHPLACE (State or foreign country) MARYLAND
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME THOMAS R. RICHARDSON		14. MOTHER'S MAIDEN NAME ELIZABETH BECK		17. INFORMANT Mr. Harry A. Richardson, Jr. 5102 Westland Blvd ST AGNES HOSP RECORDS-BALTO MD 21229	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-2272			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5626 I Aspiration Pneumonia CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: intestinal obstruction (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia, Peritonitis (C) DUE TO, OR AS A CONSEQUENCE OF: D.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 8 days 8 days years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1-31-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month <input type="checkbox"/> 1 Day <input type="checkbox"/> 1 Year <input type="checkbox"/> 1 Hour <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 31 19 70 to JUNE 5 19 70 that (I) (we) last saw the deceased alive on JUNE 5 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 06 05 70			
23C. PHYSICIAN'S NAME (Type) HIROSHI NAKAZAWA M.D.		23D. ADDRESS 3350 WILKENS AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-9-1970		24C. NAME OF CEMETERY OR CREMATORY LoudonPark Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Hubbard Funeral Home Inc. 4107 Wilkens Ave.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5803</u>	
BIRTH NO. <u>70 5803</u>		1. NAME OF DECEASED (Type or Print) <b>BAGNALL, ARTHUR MCNAMEE, SR.</b>			
2. DATE AND HOUR OF DEATH <b>6/5/70 7:30A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>40 ST. AGNES HOSPITAL</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2551</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b>			
6. CITY OR TOWN <b>BALTIMORE</b>		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <b>4013 WILKENS AVE</b>					
9. SEX <b>MALE</b>	10. RACE <b>WHITE</b>	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <b>6/23/84</b>	13. AGE (In years last birthday) <b>85</b>	14. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INTERIOR DECORATOR</b>		16. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		17. BIRTHPLACE (State or foreign country) <b>MD</b>	
18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		19. FATHER'S NAME <b>ROBERT BAGNALL</b>		20. MOTHER'S MAIDEN NAME <b>AMANDA MEYER</b>	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		22. SOCIAL SECURITY NO. <b>212099081</b>		23. INFORMANT <b>BALTO MD 212295 ST AGNES HOSP RECORDS WILKENS &amp; CATON</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Decomposition of descending colon</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Anteriorly located heart disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>5/21/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>WASS SIGMOID COLON</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>5/9/70</u> to <u>6/5/70</u> that <u>X</u> (we) last saw the deceased alive on <u>6/5/70</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles J. Lancelotta M.D.</i>				23B. DATE SIGNED <b>6 5 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES J. LANCELOTTA MD</b>				23D. ADDRESS <b>WILKENS &amp; CATON AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-8-1970</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5804</span>
BIRTH NO. <span style="font-size: 1.5em;">70 5804</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">GERTRUDE E. PFEIFER</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 3, 1970</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">00</span> <span style="font-size: 1.2em;">2019 Eagle Street Baltimore, Maryland</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2003</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2019 Eagle Street</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">July 21, 1906</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">63</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Cashier</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Vilma Movie</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">George Pfeifer</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Julia Yeager</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-34-0134</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. William C. Pfeifer, Sr. 2019 Eagle St.</span>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">410.9 I</span> <span style="font-size: 1.2em;">Massive myocardial infarction</span> <span style="font-size: 1.2em;">An old myocardial infarction</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1960</span> to <span style="font-size: 1.2em;">June 3, 1970</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">June 3, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Stanley Ankudas</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">6.5.70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Stanley Ankudas</span>
23D. ADDRESS <span style="font-size: 1.2em;">1101 Maiden Choice Lane, Balto., Md. 21229</span>				
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">6-8-1970</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>		

Miss M. M. M.

My dear Miss M. M. M.

Yours truly

John M. M.

John M. M.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5805	
BIRTH NO. 70 5805		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MC NAMARA, WILLIAM J		2. DATE AND HOUR OF DEATH JUNE 4, 1970 9:55A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE ARBUTUS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5549 ASHBOURN RD 21227			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/27/14	9. AGE (In years lost birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MICHAEL MC NAMARA		14. MOTHER'S MAIDEN NAME NORA MC NAMARA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.2		16. SOCIAL SECURITY NO. 215-05-4744		17. INFORMANT Mrs. Virginia McNamara, 5549 Ashbourne Rd. ST. AGNES HOSPITAL RECORDS	
18. 250.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes years one day 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 24 1970 to JUNE 4 1970 that (I) (we) last saw the deceased alive on JUNE 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bizhan - Ebrahimi				23B. DATE SIGNED JUNE 4, 1970	
23C. PHYSICIAN'S NAME (Type) BIZHAN EBRAHIMI		23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-1970		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) (Stolo)			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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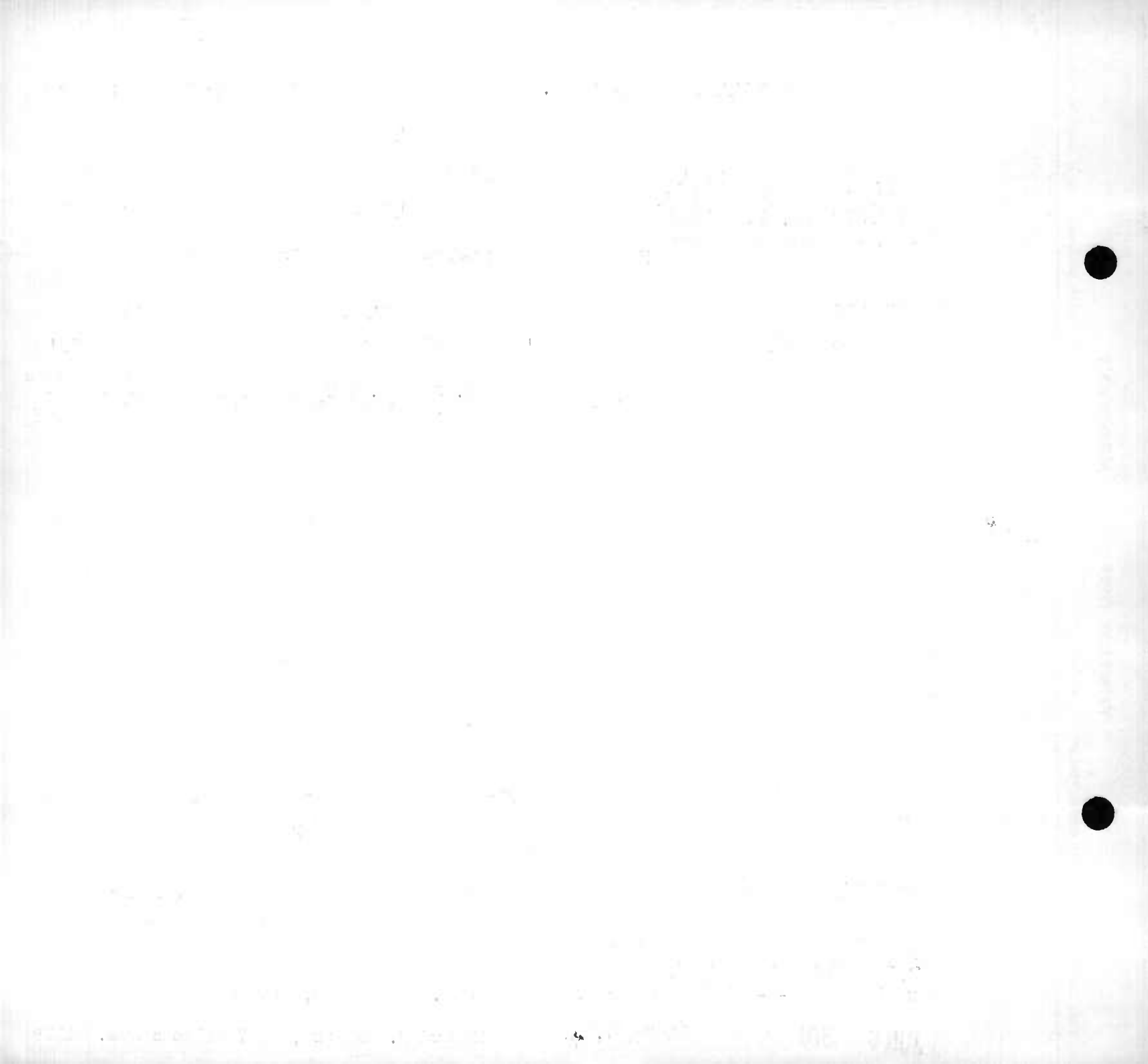
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

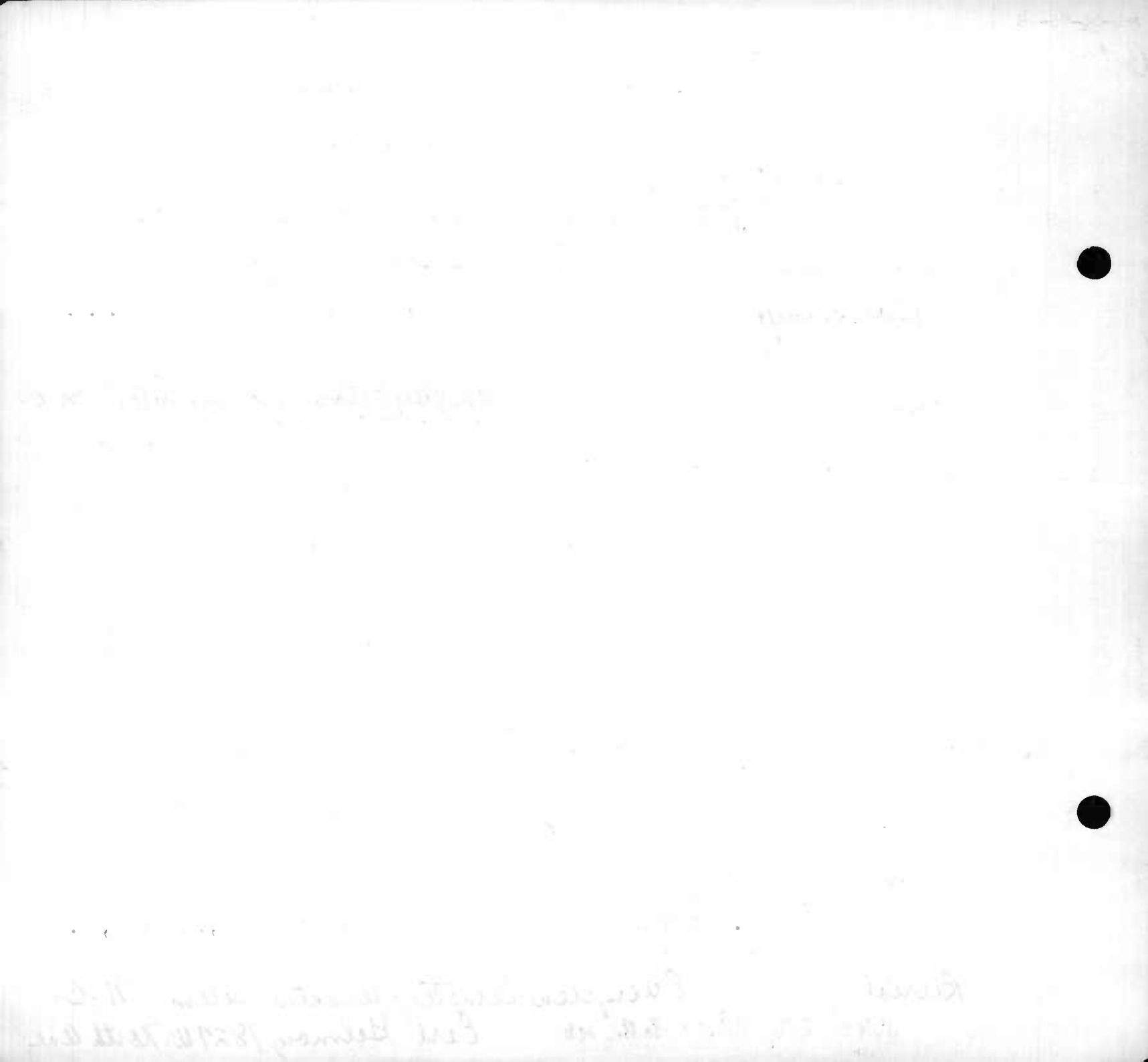
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5806</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5806</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">VERMILLION, MABEL E.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JUNE 5, 1970 12.03P M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVE. BALTIMORE, MD. 21228</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">Anne Arundel</span>	
		C. CITY OR TOWN <span style="font-size: 1.2em;">SEVERNA PARK</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">200 BALSAM DR.</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11-27-84</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">85</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">HARRISON BALDWIN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">SARAH STEWART</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-36-8507</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. John E. Vermillion, 1414 Middle Avenue</span>	
				<span style="font-size: 1.2em;">ST. AGNES RECORD ROOM WILKENS &amp; CATON AVE</span>	
18. <span style="font-size: 1.2em;">418.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Acute MI</span>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">HRS</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">A.S.C.V.D with CHF</span>		<span style="font-size: 1.2em;">Weeks</span>	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.2em;">Years</span>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">05-20</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">06-05</span> 19 <span style="font-size: 1.2em;">70</span> that (X) (we) last saw the deceased alive on <span style="font-size: 1.2em;">06-05</span> 19 <span style="font-size: 1.2em;">70</span> and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Adnan M. Sonmez</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">06-05-70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Adnan M. Sonmez</span>	
23D. ADDRESS <span style="font-size: 1.2em;">1011 Frederick Rd. Balt. MD. 21228</span>		23E. DEGREE <span style="font-size: 1.2em;">DEGREE</span>		23F. DEGREE <span style="font-size: 1.2em;">DEGREE</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6-8-1970</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Church of Ascension Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Bowie, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Howard H. Hubbard</span>		25D. ADDRESS <span style="font-size: 1.2em;">4107 Wilkens Ave. 21229</span>		25E. ADDRESS <span style="font-size: 1.2em;">4107 Wilkens Ave. 21229</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5807	
BIRTH NO. 70 5807				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Roberta B. Bray			2. DATE AND HOUR OF DEATH 6-4-1970 10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE North Carolina B. COUNTY V-30		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN Winston Salem		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-29-1918			9. AGE (In years last birthday) 51		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Byrd		
14. MOTHER'S MAIDEN NAME Ola Byrd			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Shirley Eaton - Winston Salem, N.C. Records: BCH-4940 Eastern Avenue 21224		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 1/5/30 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWEL OBSTRUCTION 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 5/30 1970 to 6/4 1970 that (I) (we) last saw the deceased alive on 6/4 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] DEGREE 23B. DATE SIGNED 6/8/70 23C. PHYSICIAN'S NAME (Type) Steven J. Friedman DEGREE 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALTIMORE CITY HOSPITAL 21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery 24D. LOCATION (City, town, or county) (State) Winston Salem, N.C. 25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Earl Helms, 1827 W. North Ave					





1  
H-616

70 5808

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5808

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT H. HARPER

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ 6 5 70 1:20 PM.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2446 Callow Ave. D.OA.

3. DATE PRONOUNCED DEAD Month Day Year Hour  
June 5, 1970 1:20 PM.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1301

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

12/3/1897

10. AGE (In years lost birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2446 Callow Ave.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert Harper

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Octavia Jordan

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

212-01-1583A

18. INFORMANT

ADDRESS

Cecilia Steptoe - 2446 Callow Ave

19.

412.41

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Tsodore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/9/70

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county) (State)

Balto.

Md

25A. DATE REC'D BY HEALTH DEPT.

JUN 8

1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Earl Gilmore - 1827 W. North Ave

1841/1842

Virginia

Robert Harper  
Gentle Partner

212-1122-2111

1841/1842



Robert Harper  
Gentle Partner

212-1122-2111

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 5809				70 5809	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>PERRY, WILLIAM P.</b>			2. DATE AND HOUR OF DEATH <b>6-6-1970 12.40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital 100 N Broadway Baltimore MD. 21231</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>White</b>			E. STREET AND NUMBER <b>711 S. Ann St. MD. 21231</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>1.26.1908</b> 9. AGE (in years last birthday) <b>62 yrs</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Punch-Press Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Heating Equip.</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Vincent Gruszczyński</b>			14. MOTHER'S MAIDEN NAME <b>Apolonia Nowak</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-01-1366</b>		
17. INFORMANT <b>Bertha Wagner</b>			ADDRESS <b>911 S Ann St 21231</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <b>Jaundice, Hepatic Encephalopathy, Metastatic Liver Disease</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Jaundice, Hepatic Encephalopathy, Metastatic Liver Disease</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>6.5.1970</b> to <b>6.6.1970</b> that (I) (we) last saw the deceased alive on <b>6.6.1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abdus Samad</b>				23B. DATE SIGNED <b>6.6.1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABDUS SAMAD</b>				23D. ADDRESS <b>MD 711 S Ann St. MD. Balto 21231</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/9/70</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970 Robert E. Farber, M.D.</b>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
70 5810 CERTIFICATE OF DEATH

REG. NO. 70 5810

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA M. REBBEL

2. DATE AND HOUR OF DEATH

6-4-70

12 30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL

4940 EASTERN AVENUE #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3808 Foster Avenue

#21224

5. SEX  
Female6. RACE  
White7. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐8. DATE OF BIRTH  
7-13-149. AGE (In years  
last birthday) 55If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NICK REBBEL

14. MOTHER'S MAIDEN NAME

MAGUARITE KERN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-05-6627

17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS  
4940 EASTERN AVENUE

ADDRESS

#21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

HEPATIC COMA

~2 days

(B) DUE TO, OR AS A CONSEQUENCE OF:

CANCER OF LIVER

~6 mos

(C) DUE TO, OR AS A CONSEQUENCE OF:

CIRRHOSIS OF LIVER

~10 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 5-29-1970 to 6-4-1970,  
that (1) (we) last saw the deceased alive on 6-4-1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard K. Maza M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

6-4-70

23C. PHYSICIAN'S  
NAME (Type)

RICHARD K MAZA M.D.

23D. ADDRESS

BCH

4940 EASTERN AVENUE #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6-8-70.

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county) (State)

7401 German Hill Rd., Ba. Co., Md

25A. DATE REC'D BY HEALTH DEPT

JUN 8 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lehman &amp; Geller

901 S. Conkling St.

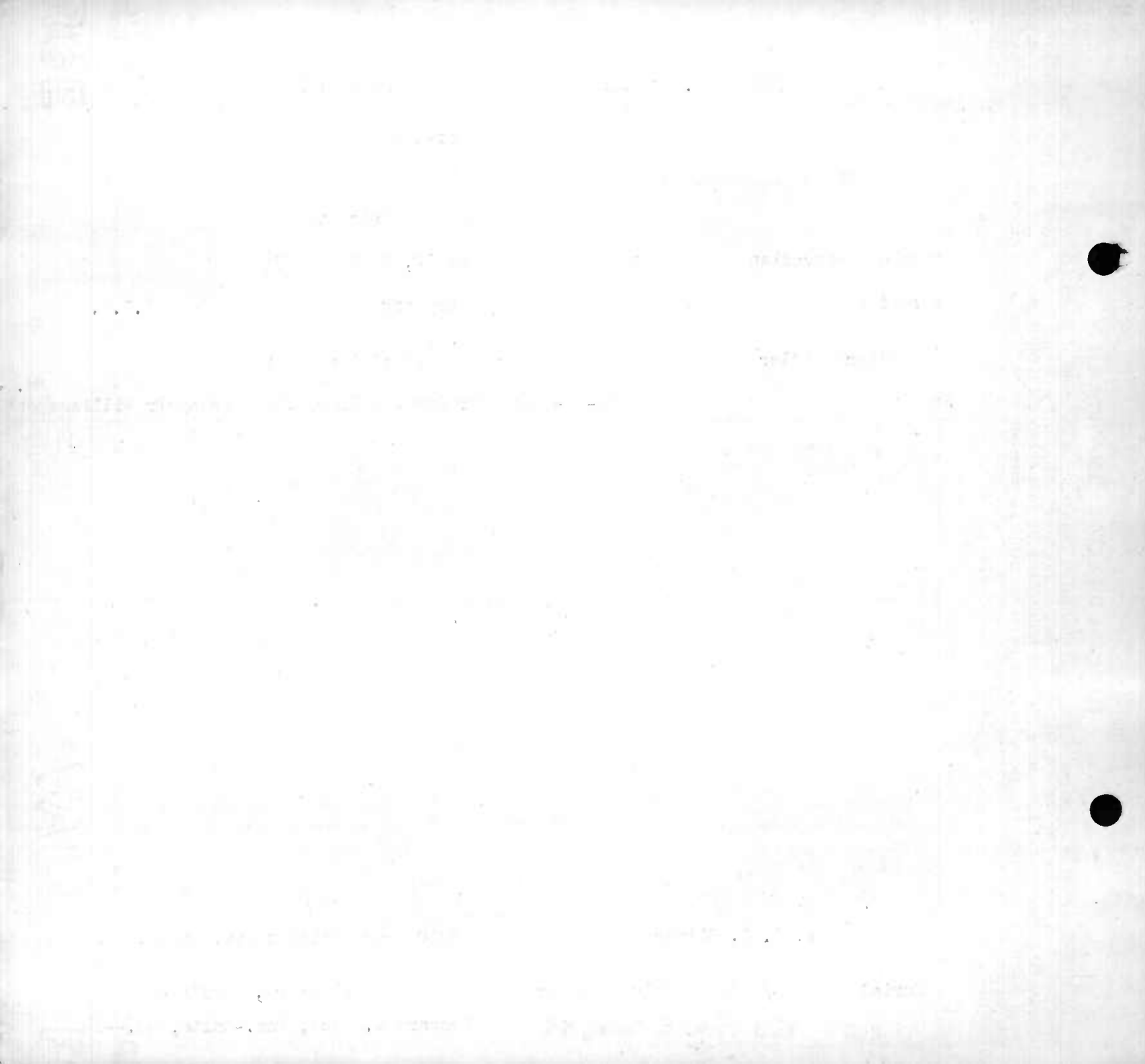
Balto., 21224, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5811</b>
BIRTH NO. <b>70 5811</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>MARY M. CLARK</b>		2. DATE AND HOUR OF DEATH <b>June 5, 1970 2 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2731</b>		
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>3202 Tyndale Ave</b>		
5. SEX <b>female</b>	6. RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 10, 1895</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Anthony Miller</b>		
14. MOTHER'S MAIDEN NAME <b>Wilhelmina ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-20-6156</b>		17. INFORMANT <b>Mr James A Clark 2706 Mosley Dr Williamsport Md.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4124122301 A. Acute Pulmonary infection Bacterial pneumonia C. V.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>		<b>18 years</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>10/13/1969</b> to <b>6/5/1970</b> , that (I) (we) last saw the deceased alive on <b>5/18/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Dr. A. A. Silver</b>		23B. DATE SIGNED <b>6/5/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. A. A. Silver</b>
23D. ADDRESS <b>6210 Park Heights Ave, Balto, Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/8/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.-Balto, Md.--14</b>

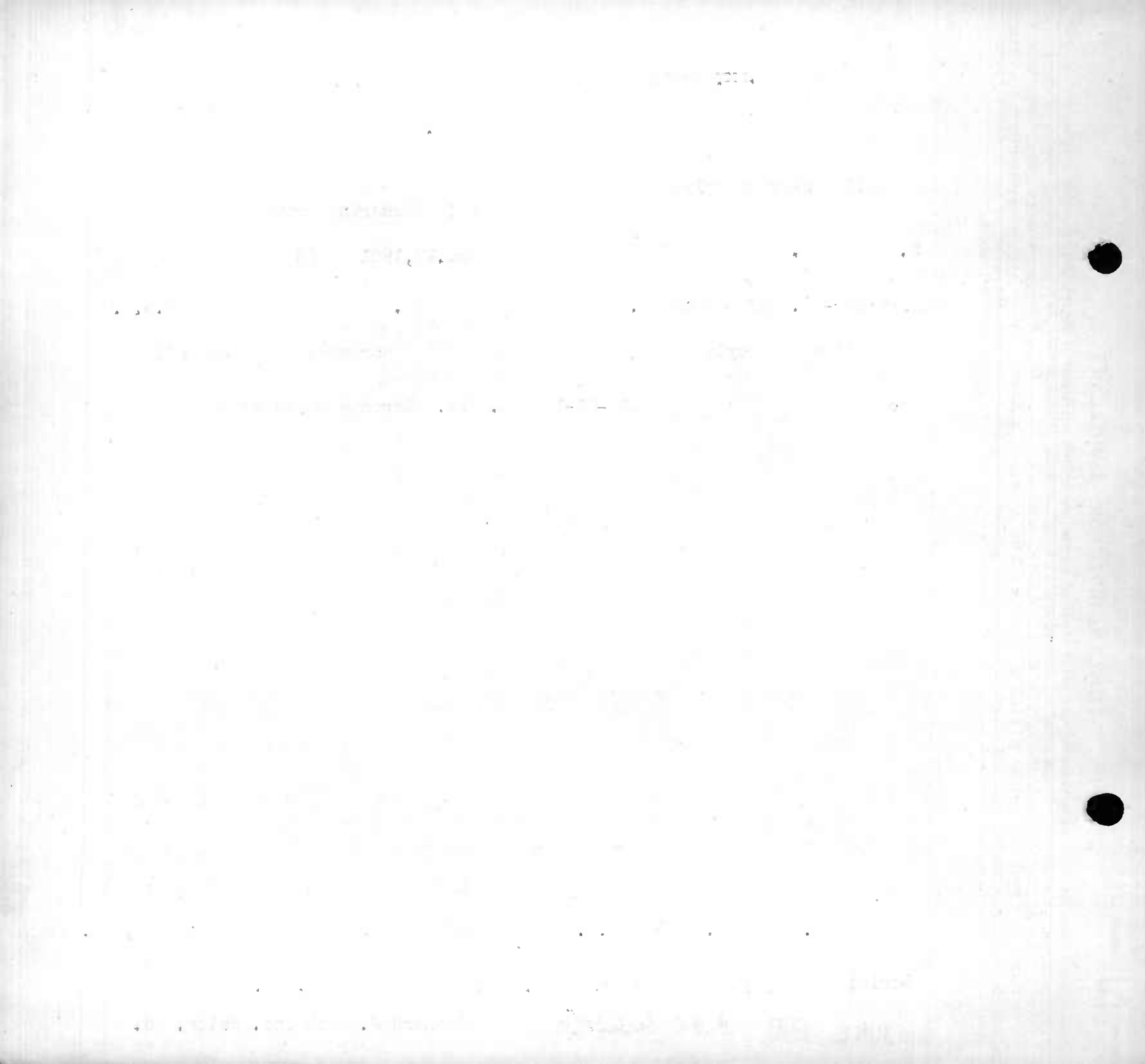




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

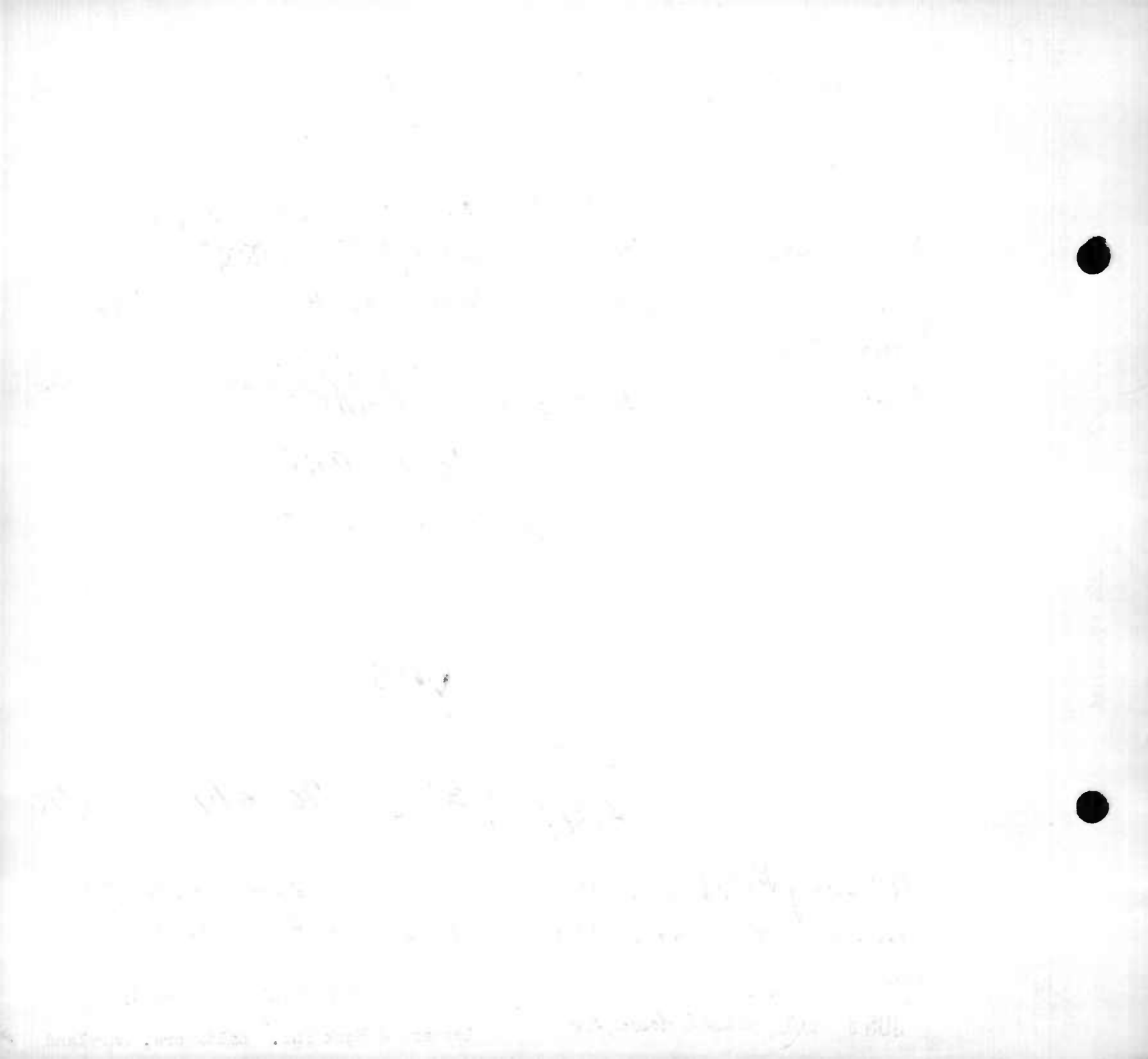
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5812</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5812</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">John C. Doyle</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6/5/70</span> <span style="float: right;">5:00 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">00 2411 Pickering Drive</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">2737</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">2411 Pickering Drive</span>		
5. SEX <span style="font-size: 1.2em;">M.</span>	6. RACE <span style="font-size: 1.2em;">W.</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Dec. 27, 1901</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Supervisor- C. Hoffberger Co.</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">William Doyle</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Margaret Donnelly</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-01-1885 A.</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Florence Doyle -same</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <span style="font-size: 1.5em;">ACUTE MYOCARDIAL INFARCTION</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4-4-1970</span> to <span style="font-size: 1.2em;">6-5-1970</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-28-1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Larry G. Tilley</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">6-6-70</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Larry G. Tilley M.D.</span>			23D. ADDRESS <span style="font-size: 1.2em;">1713 Taylor Avenue Baltimore, Md. 21234</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/8/70</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Moreland Mem. Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Leonard J. Ruck Inc. Balto. Md.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5813</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5813</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CHARLES A. CURTIS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6/4/70 12:35 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">44 UMH BALTO. MD, 21218</span>		A. STATE <span style="font-size: 1.2em;">MD</span>		B. COUNTY <span style="font-size: 1.2em;">BALTO</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">2110 HAMILTON AVE</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">8/4/85</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Watchman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Wilson Line</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VIRGINIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">CHARLES CURTIS</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Alice Gale</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-09-9350</span>	
17. INFORMANT <span style="font-size: 1.2em;">Benjamin Curtis</span>		ADDRESS <span style="font-size: 1.2em;">Same</span>		18. CAUSE OF DEATH <span style="font-size: 1.2em;">3-7-9-21</span>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">COPD, CHF</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <span style="font-size: 1.2em;">Pleural effusion Pulmonary edema</span>		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2/</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6/3/70</span> to <span style="font-size: 1.2em;">6/4/70</span> and that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">6/4/70</span> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Harvey B. Sher M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">6/4/70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HARVEY B. SHER M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">UNION MEM. HOSP.</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			
24B. DATE <span style="font-size: 1.2em;">6/9/70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Glen Haven</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J Ruck Inc. Baltimore, Maryland</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

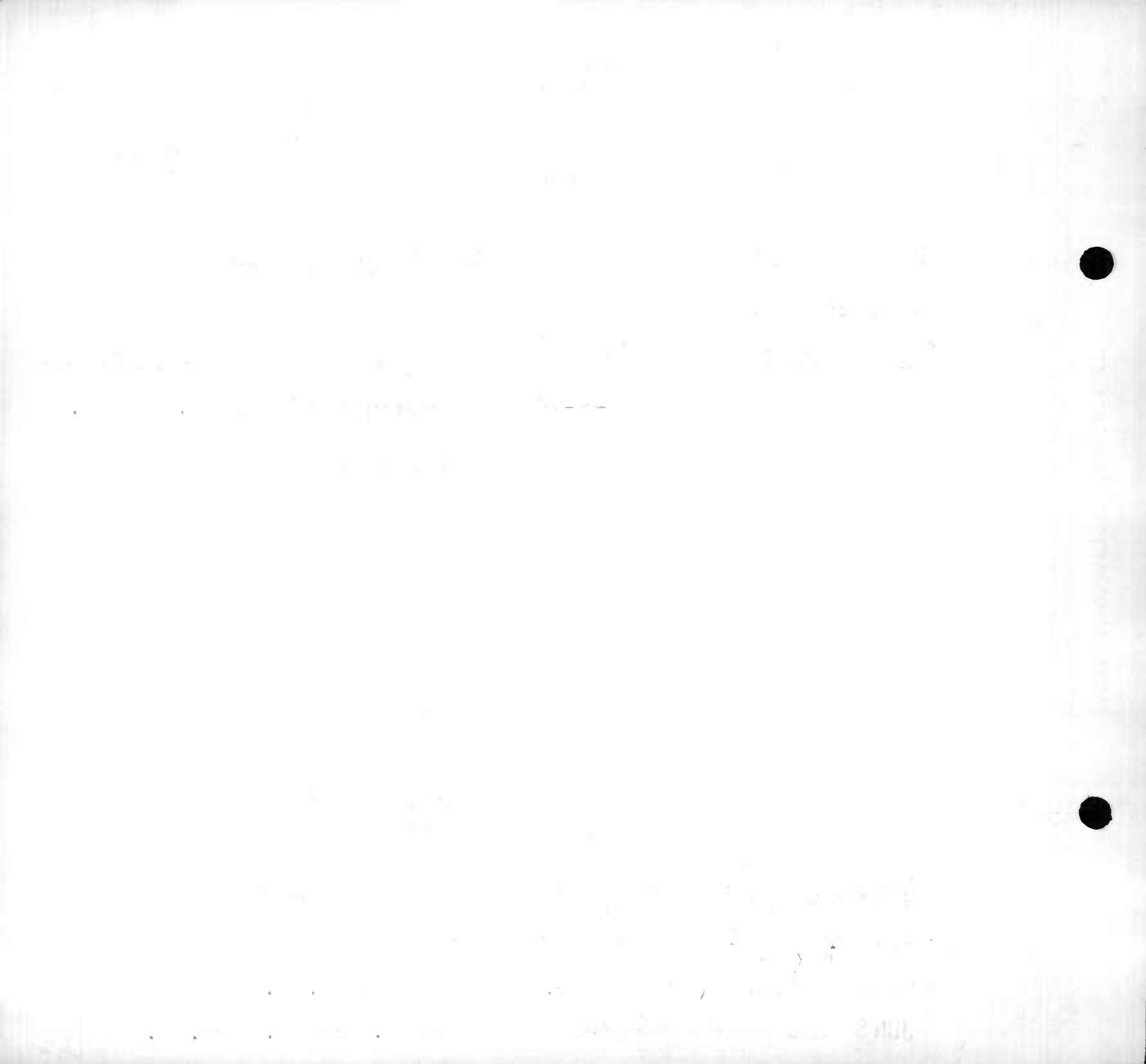
6/23/70 - Carcinoma of Transverse  
Colon

Letter from Md. Gen. Hosp  
in Bur. of Bv-Lab's file  
92.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5815		70 5815	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY B. MUNRO</b>				2. DATE AND HOUR OF DEATH <b>6/6/70 16:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 UNION MEM. HOSP</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEM. HOSP</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				E. STREET AND NUMBER <b>3100 LOUISE AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/92</b>		9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>GEORGE H. BURGES</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE Molter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-05-0354B</b>		17. INFORMANT <b>CHARLES Gilbert L. Munro Sr. same</b>	
18. <b>4/12/21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HAECVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> 19 <b>70</b> and that (I) (we) last saw the deceased alive on <b>6/6</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harvey B. Sher M.D.</b>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>HARVEY B. SHER M.D.</b>				23D. ADDRESS <b>UMH</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/10/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		ADDRESS	



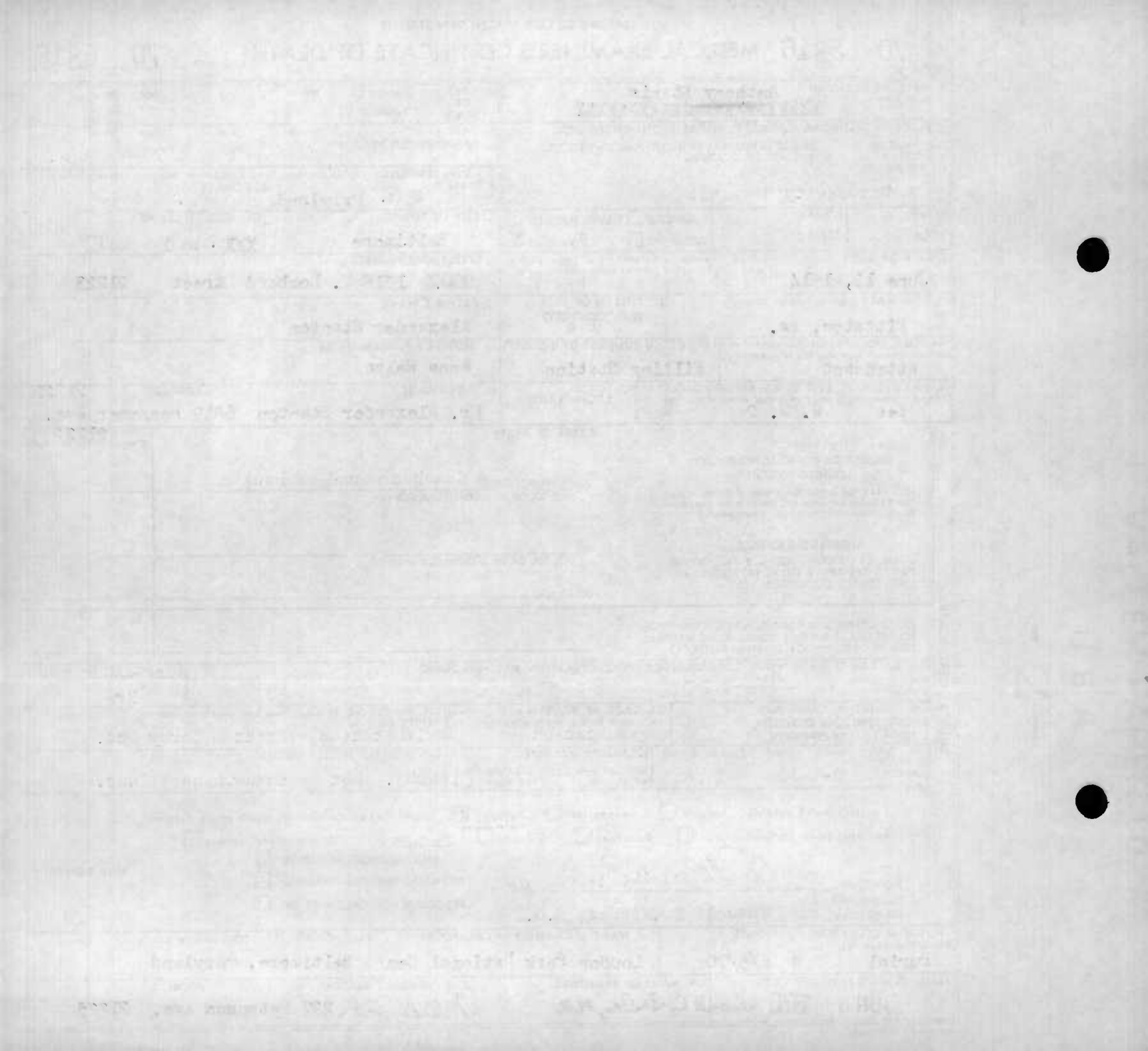


70 5816 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5816

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Anthony Stanis</b> <del>XXXXXXXXXXXXXXXXXXXX</del>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 1 1970 6 A.</b> M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Unk. Maryland</b> B. COUNTY <b>Unk.</b> <b>301</b>	
9. DATE OF BIRTH <b>June 13, 1914</b>		10. AGE (In years lost birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittston, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		15. MOTHER'S MAIDEN NAME <b>Anna Welza</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. 2</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr. Alexander Stanton</b>		ADDRESS <b>6819 Bessemer Ave. 21222</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E965 X</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <b>Gunshot wound of back</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>gas station</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Gulf Station - Pratt &amp; Carey Sts. 1803</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22D. TIME OF INJURY (APPROX.) <b>6-1-70 ? A. m.</b>		22F. HOW DID INJURY OCCUR? <b>Subj. shot by unknown assailant.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/5/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>McElroy F.H.</b>		ADDRESS <b>237 Patapsco Ave. 21225</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-5321

BALTIMORE CITY HEALTH DEPARTMENT

70 5817

CERTIFICATE OF DEATH

REG. NO.

70 5817

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EILEEN SCHNETZKA

2. DATE AND HOUR OF DEATH

12:40 PM 6/6/70

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE B. COUNTY

MARYLAND

BALTO

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

309 CHALFONTE DRIVE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7-24-18

9. AGE (in years lost birthday)

51

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Social Security U. S. Government

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

WILLIAM SULLIVAN

14. MOTHER'S MAIDEN NAME

ANNIE CHANEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-26-8799

17. INFORMANT

Mr. Joseph M. Schnetzka, 309 Chalfonte Drive

ADDRESS

18. 199.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(R) Hemispherical Hemorrhage 8 hours

(B) DUE TO, OR AS A CONSEQUENCE OF:

Pass chronic consumption congested

(C) DUE TO, OR AS A CONSEQUENCE OF:

Weak states adenocarcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 25, 1970 to June 6, 1970 that (I) (we) lost saw the deceased alive on June 6, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter Tomasulo MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/6/70

23C. PHYSICIAN'S NAME (Type)

PETER TOMASULO

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/9/70

24C. NAME of CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION (City, town, or county) (State)

Dorsey, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 8 1970

25B. NAME OF REGISTRAR

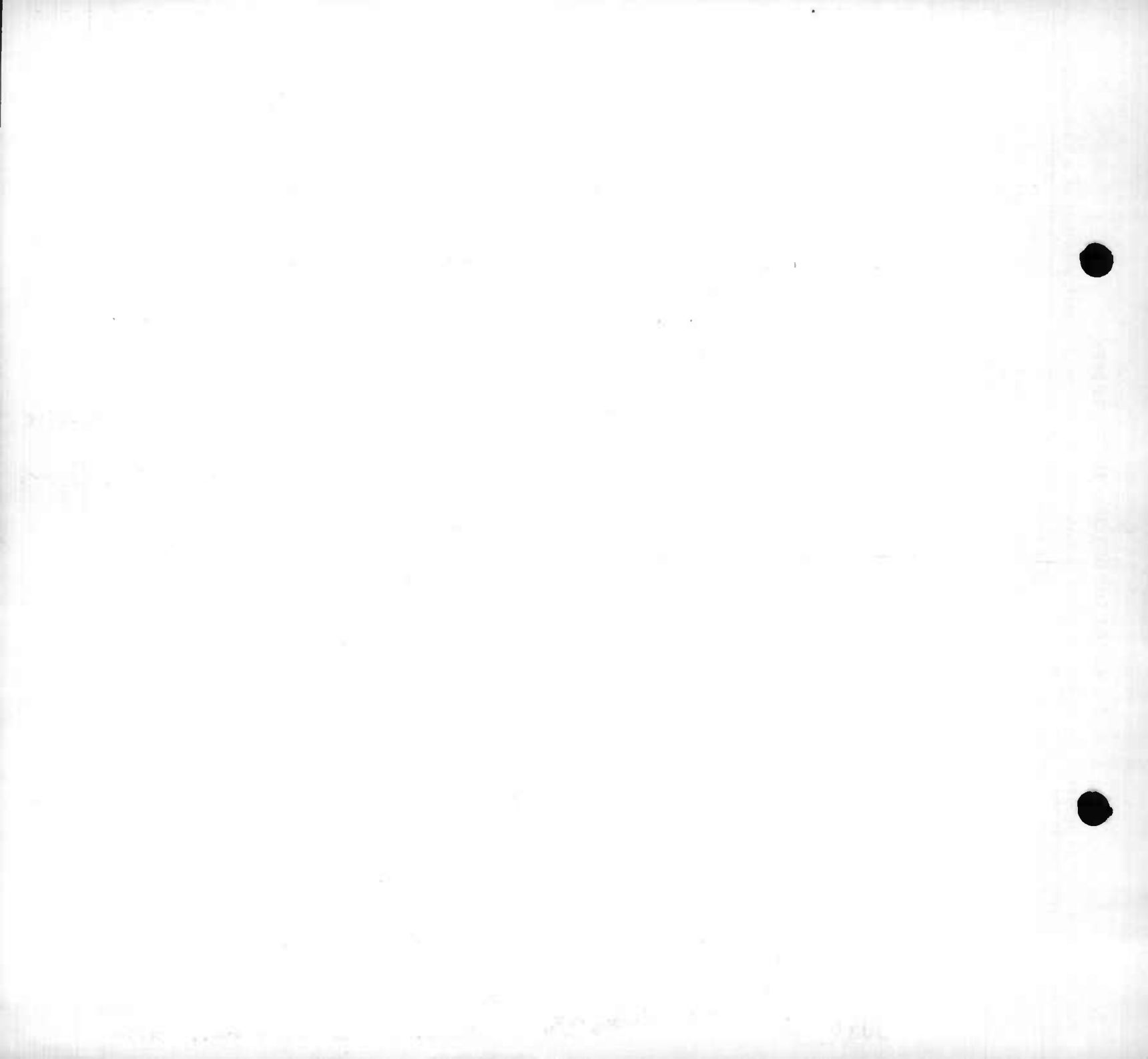
E. E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Witzke, 1630 Edmondson Ave.,

ADDRESS

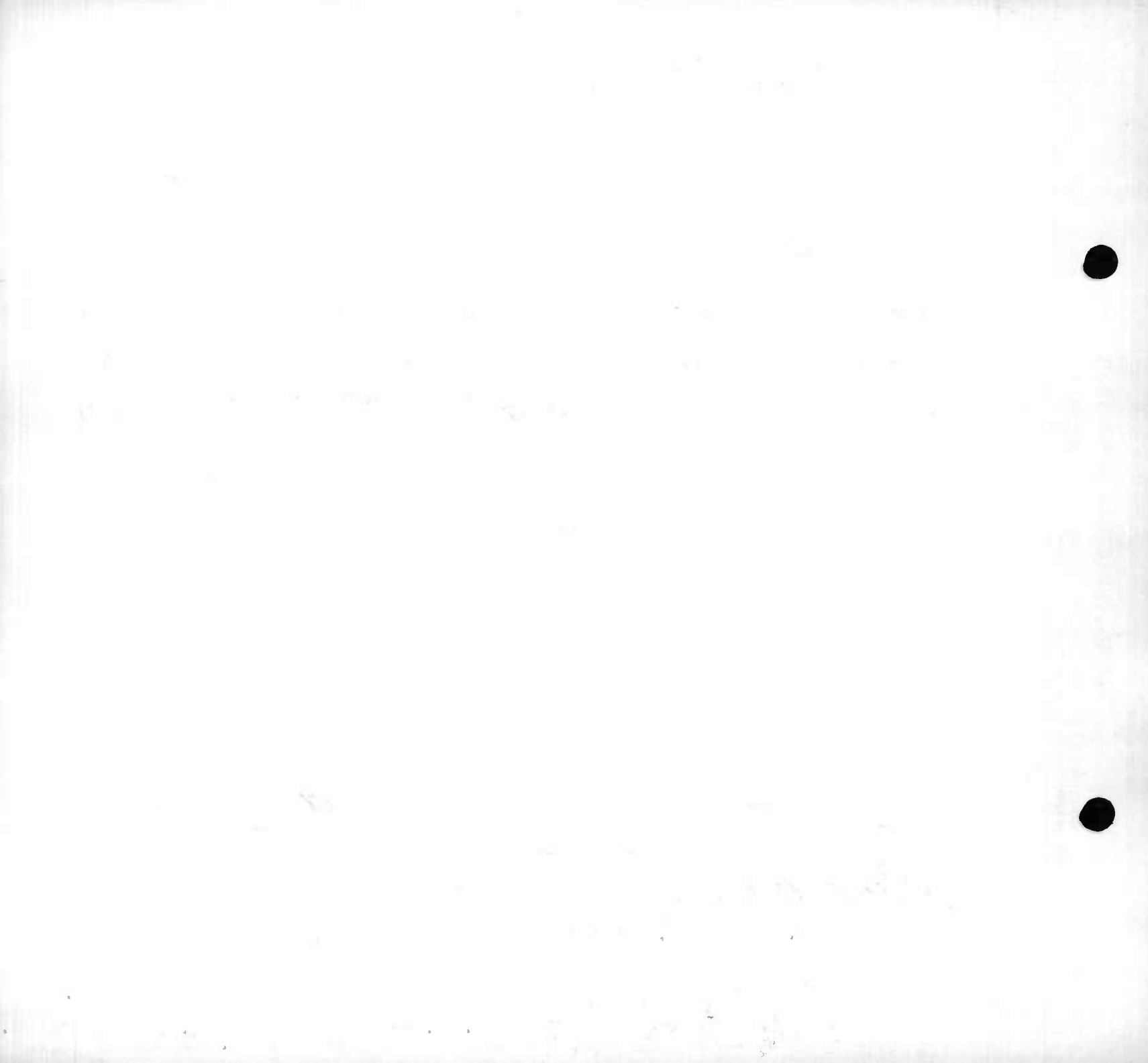
2228



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

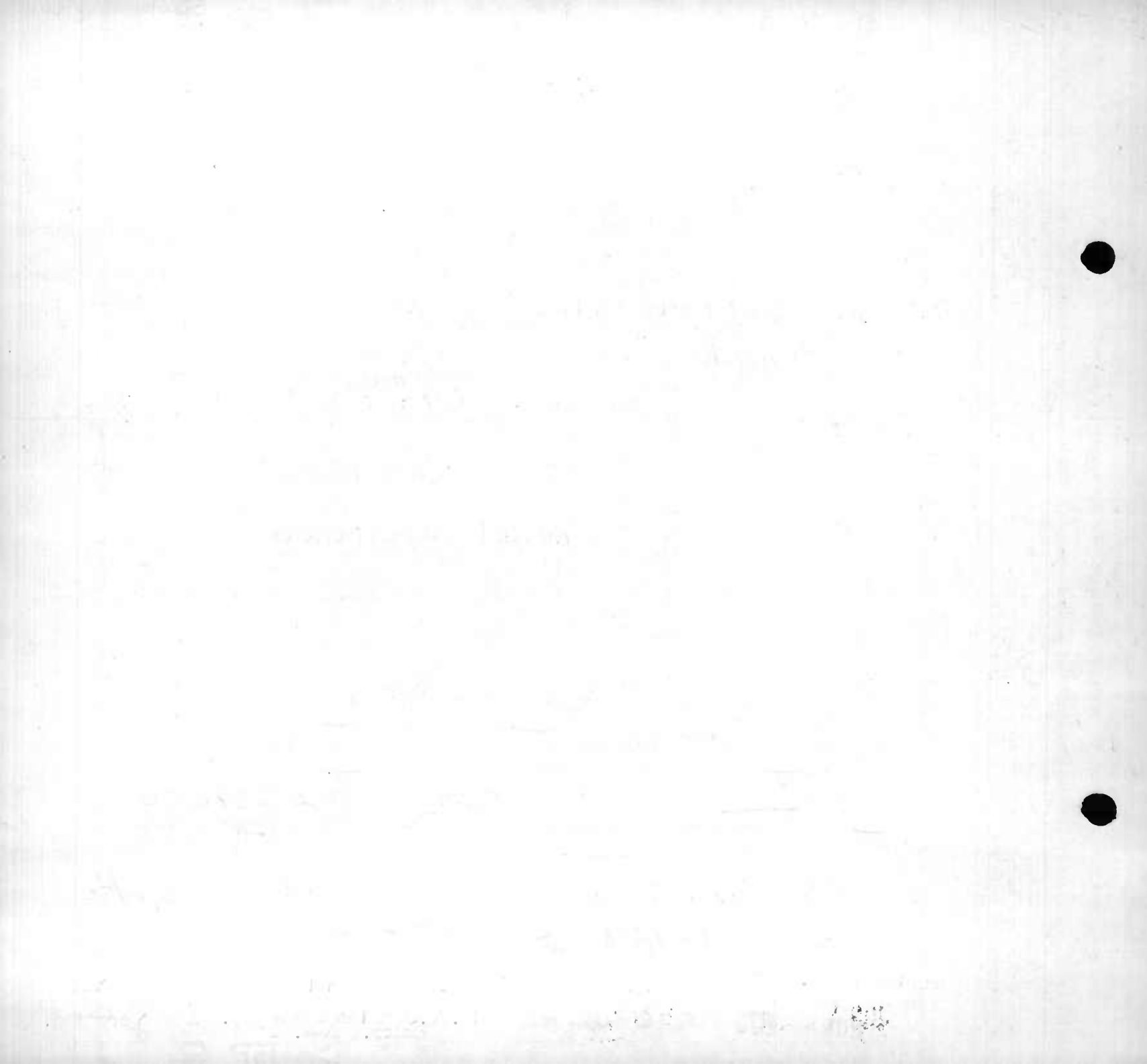
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X	REG. NO.	70 5818
BIRTH NO. 70 5818		1. NAME OF DECEASED (Type or Print) <b>EDWARD A. LYSTON</b>		2. DATE AND HOUR OF DEATH <b>6/7/70 10<sup>15</sup> A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House In Pines 5837 Belair Rd 21206</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto.</b>		C. CITY OR TOWN <b>BALTIMORE 21224</b>		
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/1899</b> 9. AGE (In years last birthday) <b>70</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>KOESTER'S</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		
13. FATHER'S NAME <b>WILLIAM LYSTON</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE GEBHARDT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-6697</b>		17. INFORMANT <b>MRS. ELIZABETH C. LYSTON (SAME)</b>		
18. <b>4/10/91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Embolic Stroke</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Multiple Stroke</b> DUE TO, OR AS A CONSEQUENCE OF:				
		(C) <b>Chronic Arteriosclerosis</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Chronic Urinary Tract Infection</b>						
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9/1964</b> to <b>6/7/70</b>		that (I) ( <del>we</del> ) last saw the deceased alive on <b>6/5/1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>Albert B Bradley</b>		23B. DATE SIGNED <b>6/7/70</b>				
23C. PHYSICIAN'S NAME (Type) <b>Dr. Albert B. Bradley</b>		23D. ADDRESS <b>4900 Belair Road</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/10/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5819</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5819</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Heinrich, Egon Osteen</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6/6/70 7:07 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">ANNE ARUNDEL 5200</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">2X USPHS Hosp. Balt., Md.</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Pasadena</span>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
			E. STREET AND NUMBER <span style="font-size: 1.2em;">Box 350 Rt. 8</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">Cauc.</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8/27/31</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">38</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Instr. for School</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Marine Engineer</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">NY</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Hans Heinrich</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Moselle Osteen</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">091 24 0081</span>			17. INFORMANT <span style="font-size: 1.2em;">MRS. AGNES ROBERTS</span> ADDRESS <span style="font-size: 1.2em;">(Chart) 26 South St. Baltimore, Md. 21201</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">189.01</span>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Carcinomatosis</span> mos.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <span style="font-size: 1.2em;">Renal carcinoma</span> mos. (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2 0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">0</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">no</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">Yes</span>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/29</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6/6/70</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6/6</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Peter J. Philpott MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">6/6/70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Peter J. Philpott MD</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial Rem.</span>			24B. DATE <span style="font-size: 1.2em;">6-10-70</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Oneida Castle Cemetery</span>
24D. LOCATION <span style="font-size: 1.2em;">Oneida, New York</span>			25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jenkins, Jr.</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">H. W. Jenkins Sons Co. Balto., Md. 21212</span>		





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5820</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">M 3201</span> <span style="font-size: 1.5em;">70 5820</span> <span style="font-size: 1.5em;">70 5820</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sydney W. Matthews		June 5-70 9 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Md.		
00 208 E. Coldspring Lane			B. COUNTY 2711		
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-27-1882	
Homemaker		Own Home		9. AGE (In years last birthday) 88	
13. FATHER'S NAME William G. Wetherall		14. MOTHER'S MAIDEN NAME Sydney A. ?		11. BIRTHPLACE (State or foreign country) Harford Co., Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Dr. W. H. Woody			ADDRESS 1403 Park Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure Atherosclerosis Heart Dis Hypertension advanced. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs Gradual					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1936 to June 5 1970, that (I) (we) last saw the deceased alive on June 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Woody MD				23B. DATE SIGNED 6-5-70	
23C. PHYSICIAN'S NAME (Type) Dr. W. H. Woody				23D. ADDRESS 1403 Park Ave. Baltimore Md 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-70		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Faber, MD		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 5821				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5821	
1. NAME OF DECEASED (Type or Print) <b>MOORE, WILLIAM, B</b>				2. DATE AND HOUR OF DEATH <b>6-5-70 1:15 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2102</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH BALTIMORE GENERAL HOSPITAL 3001 S. HANOVER ST. BALTO., MD. 21230</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/5/1909</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Electric Co. New Jersey</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Y. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-26-8405</b>		17. INFORMANT <b>Mrs Mary Moore</b>		ADDRESS <b>above</b>	
18. <b>571.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATO RENAL SYNDROME</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEPATO RENAL SYNDROME</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>PORTAL CIRRHOSIS</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC ALCOHOLISM</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 30</b> 19 <b>70</b> to <b>JUNE 5</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>JUNE 5</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Cecilia V. Tombe</b>				23B. DATE SIGNED <b>June 5, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>MD</b>	
23D. ADDRESS <b>SOUTH BALTIMORE GEN. HOSPITAL</b>				23E. FUNERAL DIRECTOR <b>John J. Cowan &amp; Son Inc.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/9/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Camp</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John J. Cowan &amp; Son Inc.</b>		25D. ADDRESS <b>23, W. ...</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 5822	
BIRTH NO. 70 5822		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 6/4/70 5:30 A.M.			
1. NAME OF DECEASED (Type or Print) Zola Virginia Black				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) Md. CARROLL CO. 5600			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. MD BALT MD.				C. CITY OR TOWN New Windsor		D. INSIDE CITY LIMITS? YES	
				E. STREET AND NUMBER 338 MAIN ST			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/11	9. AGE (in years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD JESS				14. MOTHER'S MAIDEN NAME YERGIE STULTZ Md.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-05-7390		17. INFORMANT HUSBAND		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary-CARDIAC arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last)				(B) DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction		3 days	
				(C) Heart block			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/3 1970 to 6/4 1970 that (I) (we) last saw the deceased alive on 6/4 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (d/d) (did not) view the body after death.							
23A. SIGNATURE Howard Wallach, MD				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/4/70	
23C. PHYSICIAN'S NAME (Type) HOWARD WALLACH				23D. ADDRESS UNIV. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/6/70		24C. NAME OF CEMETERY OR CREMATORY UNITED BRETHREN		24D. LOCATION (City, town, or county) (State) TANEYTOWN MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR		ADDRESS NEW WINDSOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 70-0839870 5823					CERTIFICATE OF DEATH X					REG. NO. 70 5823				
1. NAME OF DECEASED (Type or Print) FAUX BABY BOY					2. DATE AND HOUR OF DEATH MAY 20 1970 12:15PM M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALCO. 5200									
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229					C. CITY OR TOWN BALTIMORE					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER 4928 BROOKWOOD ROAD 21225														
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05/19/70		9. AGE (in years last birthday) 1		II Under 1 Yr. Months Days		II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY? U S A					13. FATHER'S NAME HAROLD E FAUX JR					14. MOTHER'S MAIDEN NAME JEAN L DUFF				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.					17. INFORMANT ST AGNES HOSP BALTIMORE MD 21229				
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Abscess (B) Fetal dysmaturity Syndrome DUE TO, OR AS A CONSEQUENCE OF: (Hyaline membrane disease). (C)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
MEDICAL CERTIFICATION					19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) NO YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 05/19/70 19 to 05/20/70 19 that (X) (we) lost saw the deceased alive on 05/20/70 19 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.														
23A. SIGNATURE deceased - almost					23B. DATE SIGNED 5/22/70									
23C. PHYSICIAN'S NAME (Type) MA. JOSEPHINA DE CASTRO MD					23D. ADDRESS WILKENS & CATON BALTO MD 21229									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/6/70					24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery				
24D. LOCATION (City, town, or county) (State) Baltimore, Md.														
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970					25B. NAME OF REGISTRAR Robert E. Farber, M.D.					25C. FUNERAL DIRECTOR Vitzke, 4101 Edmondson Ave., 21229				

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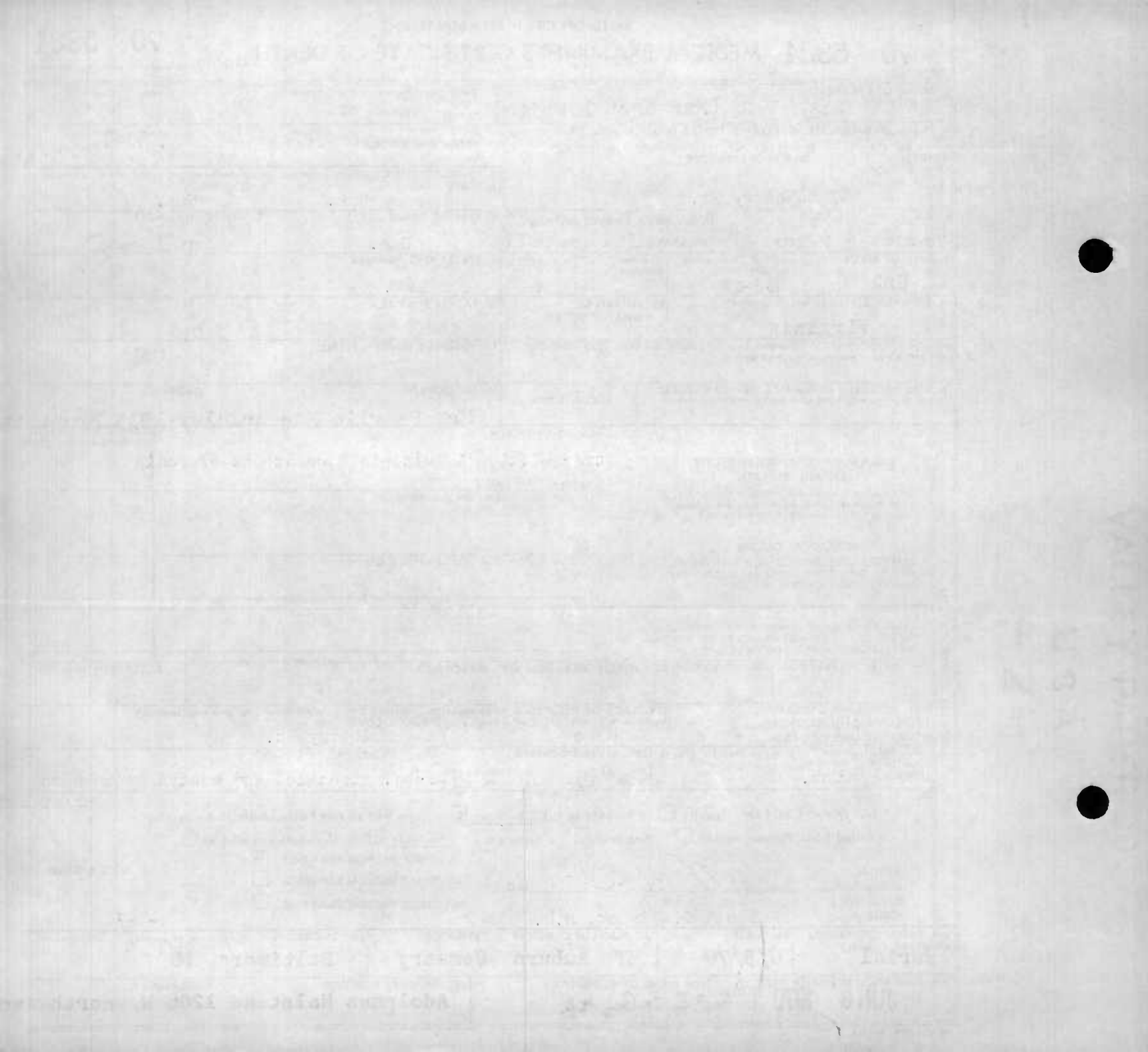
70 5824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 5824

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARY WHITE (Margaret L White)		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
00 647 Mulberry St.		6 1 1970					12:30 A.M.
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Unk.	
9. DATE OF BIRTH Unk		10. AGE (In years last birthday) 55-65		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY Unk.	
13. FATHER'S NAME Unk		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Unk		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Pearlle Mae Bradley 1935 Brunt St		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Strangulation & multiple lacerations of scalp (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 647 Mulberry St. 402		24. HOW DID INJURY OCCUR? Subj. strangled and beaten by unknown assailant	
25. TIME (Month) (Day) (Year) (Hour) Unk.		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27. DATE OF OPERATION 6/5/70		28. CONDITION FOR WHICH OPERATION WAS PERFORMED	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. ACTUAL EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		31. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		32. DATE SIGNED 6-1-70	
33. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		34. 24B. DATE 6/5/70		35. 24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		36. 24D. LOCATION (City, town, or county) (State) Baltimore MD	
37. 25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		38. 25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		39. 25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W north Ave		40. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5825</span>	
30 5825 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Madre, William E.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5-29-70 12:10 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">GRANADA NURSING HOME</span> <span style="font-size: 1.2em;">4017 LIBERTY HEIGHTS AV</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">1538</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">3624 FAIRVIEW AV</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/26/02</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">67</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer -</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">-</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">JERRY Madre</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ida -</span>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-10-0552</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs Naomi G Knox, 1605 Bruce Court</span>	
18. <span style="font-size: 1.2em;">410.9 I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CORONARY THROMBOSIS</span>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/3/70</span> 19 to <span style="font-size: 1.2em;">5/29/70</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/29/70</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">HOLLIS JENNARINE, MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/29/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HOLLIS JENNARINE, MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">1801 Greenberry Rd</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6/6/70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">MT Auburn Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore M,</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, MD</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Adolphus Halstead 1206 W North Ave</span>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 5826</b>	
BIRTH NO. <b>70 5826</b>		DATE AND HOUR OF DEATH <b>June 3, 1970 1:45 A.</b>	
1. NAME OF DECEASED (Type or Print) <b>Rebecca Brown</b>		2. DATE AND HOUR OF DEATH <b>June 3, 1970 1:45 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>806</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>31 4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-6-16</b>	
9. AGE (in years last birthday) <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Brown (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Loney Thomas (Deceased)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: Records Baltimore, Maryland 21224</b>		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>312X I</b> <b>CARDIAC FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC FAILURE</b>	
		(B) <b>INTRATHORACIC HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>24 hr.</b>	
		(C) <b>PNEUMOTHORAX</b> DUE TO, OR AS A CONSEQUENCE OF: <b>24 hr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>BOWEL OBSTRUCTION</b>		<b>4 hr.</b>	
19A. DATE OF OPERATION <b>5/29, 6/2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BOWEL OBSTRUCTION, HEMORRHAGE</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/29</b> 19 <b>70</b> to <b>6/3</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/3</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>STEVEN J. FRIEDMAN M.D.</b>		23B. DATE SIGNED <b>6/3/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEVEN J. FRIEDMAN M.D.</b>		23D. ADDRESS <b>4940 Eastern Avenue Balto. Md.</b> <b>BALTO. CITY HOSP.</b> <b>21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/6/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Vaiber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North A e</b>	

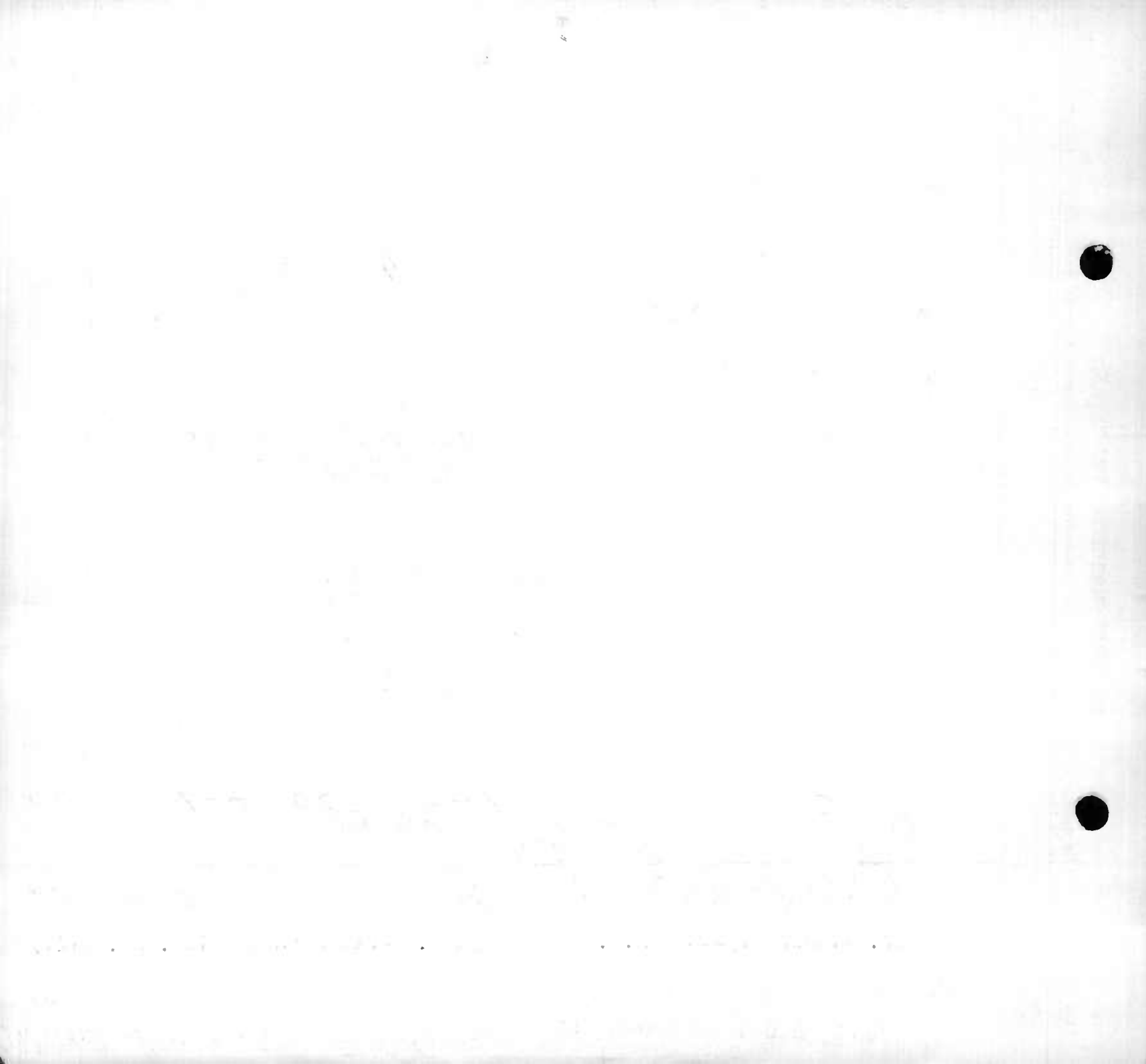
1354 Address:

2018 E. LORVIST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5827	70 5827
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lewis, Thomas A</i>		2. DATE AND HOUR OF DEATH <i>6/1/70 9 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>402</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>755 W Lexington St.</i>			
5. SEX <i>Male</i>	6. RACE <i>Non white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/6/1884</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rev.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Ret.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Thomas Lewis</i>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>218-10-4928A</i>		17. INFORMANT <i>Chart</i>	
				ADDRESS <i>607 Penn. Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>2-50-91</i>		CAUSE OF DEATH <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>DIABETES MELITUS</i>			
		(B) DUE TO OR AS A CONSEQUENCE OF:			
		(C) <i>EPILEPSY</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>1-2-1970</i> to <i>6-1-1970</i> that (1) (we) last saw the deceased alive on <i>6-1-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard Tyson</i>				23B. DATE SIGNED <i>6-2-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Richard Tyson M.D.</i>				23D. ADDRESS <i>936 W. North Avenue Balto. Md. 21217</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/6/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cemetery Balto. Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Md</i>		25A. DATE REC'D BY HEALTH/DEPT. <i>JUN 8 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Md</i>	
		25C. FUNERAL DIRECTOR <i>H.B. Johnson</i>		ADDRESS <i>1900 Eutaw Pl Balto. Md</i>	





1  
5-525

70 5828

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5828

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID B. JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 3 70 ? M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) VA Hospital Loch Raven Blvd. 8-77		3. DATE PRONOUNCED DEAD Month Day Year Hour June 3, 1970 ? M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 906			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Bal to D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6-25-16	10. AGE (In years last birthday) 53	11. BIRTHPLACE (State or foreign country) STANTON, VA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire Bundler		15. MOTHER'S MAIDEN NAME Rosa B. Loving	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.2		17. SOCIAL SECURITY NO. 275-07-0899	
18. INFORMANT Elena N. Johnson 1900 E. 31st St.		ADDRESS	
19. CAUSE OF DEATH E9291X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subdural hematoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unknown		22F. HOW DID INJURY OCCUR? Unknown	
22D. TIME OF INJURY (APPROX.) 6 1 70 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Toidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-70	
24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.	

CHICAGO, ILL. 6/1/71

WALLEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5829	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>John Johnny Nathan, Johnnie</i>				2. DATE AND HOUR OF DEATH <i>6/3/70</i> <i>6:45 Am</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37</i> <i>Mercy Hospital, Inc.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1001</i>	
5. SEX <i>Male</i> 6. RACE <i>negro</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>7-4-10</i> 9. AGE (in years last birthday) <i>59</i>	
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant Seaman</i>				11. BIRTHPLACE (State or foreign country) <i>Live Oak, Florida</i>	
13. FATHER'S NAME <i>John Nathan</i>				14. MOTHER'S MAIDEN NAME <i>Annie Taylor</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>219-16-8617</i>	
17. INFORMANT <i>Maggie Nathan</i>				ADDRESS <i>1410 E. Biddle St.</i>	
18. I <i>16211</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiorespiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Lung Carcinoma</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>-</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-8-1970</i> to <i>6-3-1970</i> that (I) (we) last saw the deceased alive on <i>6-2-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Randhir P. Sinha</i>				23B. DATE SIGNED <i>6/3/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>RANDHIR P. SINHA</i>				23D. ADDRESS <i>Mercy Hospital - Balto. Md. 21202</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-7-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Anne Arundel Co. Md.</i>		24E. LOCATION (State) <i>Md.</i>		24F. LOCATION (City, town, or county) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1970</i>		25B. NAME OF REGISTRAR <i>James E. Taber, MD</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>	
25D. ADDRESS <i>2431 E. Oliver St.</i>					

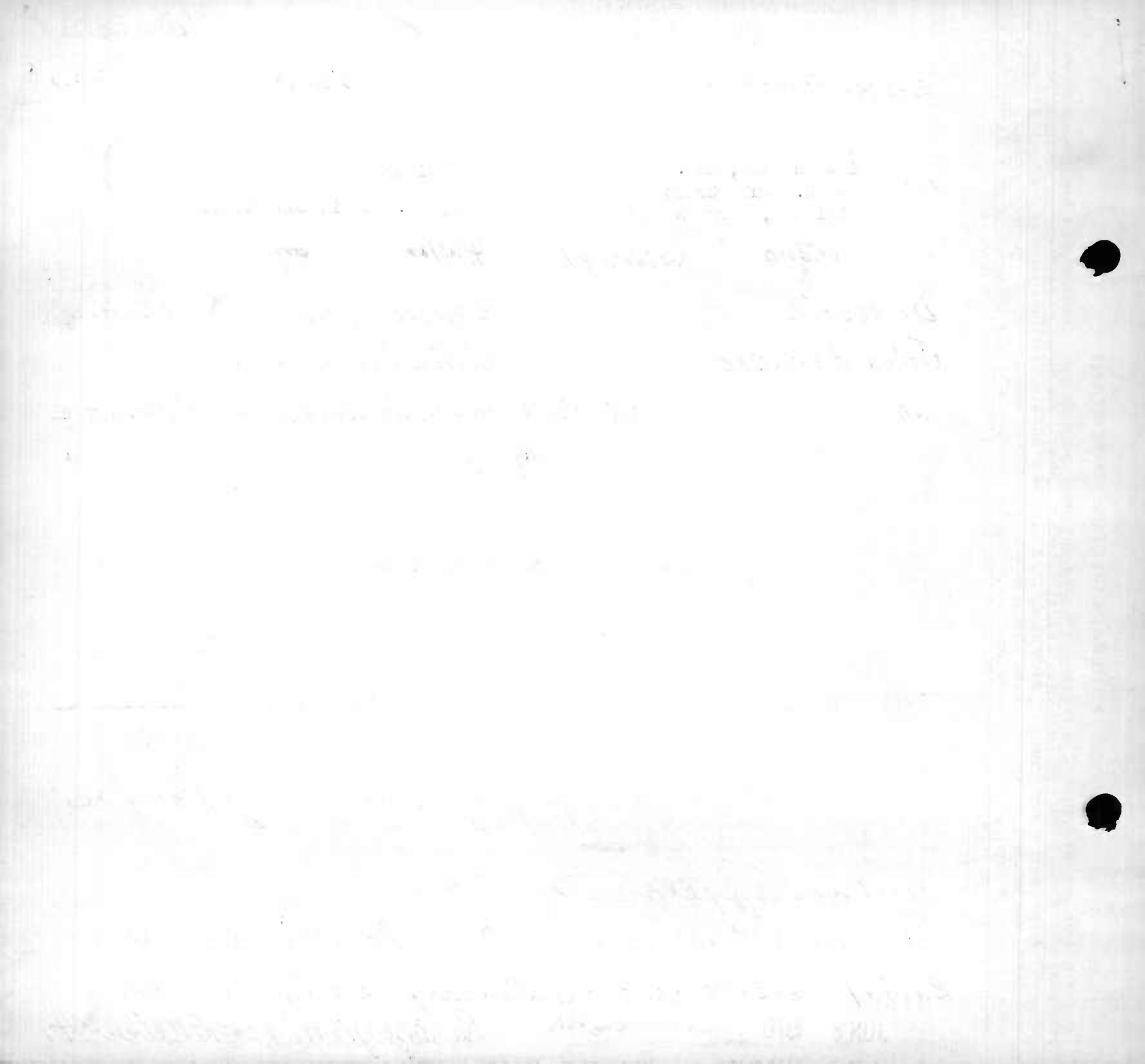
Metabolic lung carcinoma  
Cardiovascular failure

Robert L. Smith  
Lester J. Smith  
March 1964  
4/2/64

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">70 5830</span>	
BIRTH NO. <span style="font-size: 1.5em;">70 5830</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Estelle Barnes</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/31/70</span> <span style="float: right;">12:35 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202</span>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">802</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1836 N. Collington Street</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4/27/11</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">59</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">DOMESTIC</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign county) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">John Garnett</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Lillie Coleman</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-07-3201</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs Lillie Clark</span>	
18. <span style="font-size: 1.2em;">4/12/41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cardio Respiratory Failure</span> DUE TO (B) <span style="font-size: 1.2em;">Congestive Heart Failure</span> DUE TO (C) <span style="font-size: 1.2em;">Old CVA.</span>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/10/70</span> 19 to <span style="font-size: 1.2em;">5/31/70</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/10/70</span> 19 and that in (my) <span style="font-size: 1.2em;">last</span> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">William D Applefield</span> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">William D Applefield</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">6615 Reisterstown Rd.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">6-3-70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Auburn Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 8 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Randolph J. Edlick</span>		25D. ADDRESS <span style="font-size: 1.2em;">2431 E. Oliver St.</span>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DAVID P. MOSES

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

6

2

70

12:50 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Balto. General Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

June

2,

1970

12:50 p.m.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

3/24/46

10. AGE (In years  
last birthday)

24

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

740 Belgian Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

ALTON MOSES

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Geneva Childs

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Ruby Moses - 740 Belgian Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of the head  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
Street22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2312 Annapolis Ave.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

6

2

70

9:48a

22E. INJURY OCCURRED  
WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot during attempted hold-up

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/6/70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Westport, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 8

1970

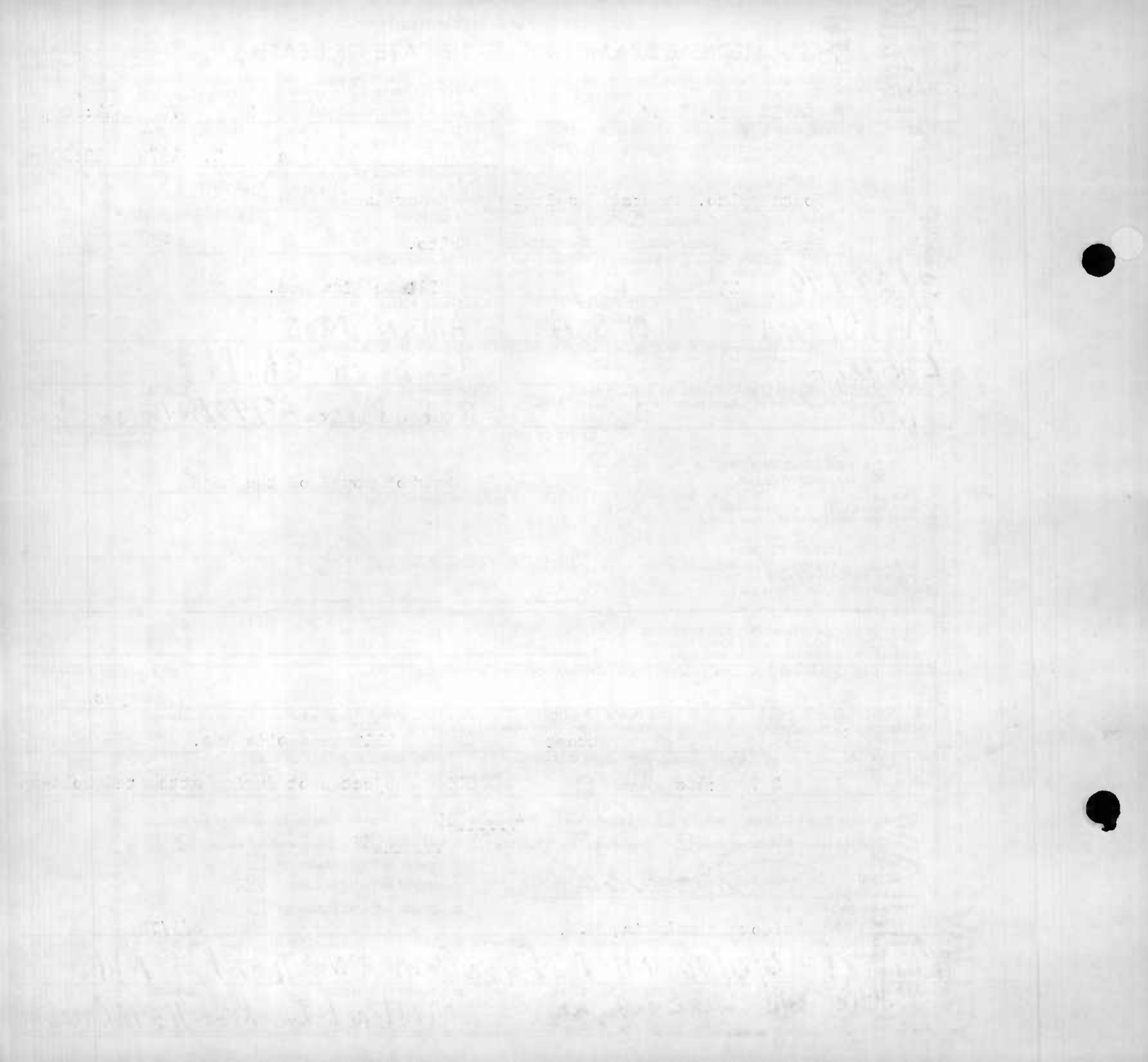
25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Milton F. Erickson - 1129 N. Caroline St.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 5832		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5832	
1. NAME OF DECEASED (Type or Print) <i>Moses JAMES</i>		2. DATE AND HOUR OF DEATH <i>6/5/70</i> <i>10:55 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 THE JOHNS HOPKINS HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE CITY</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>910 N. DURHAM STREET</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-10</i>	9. AGE (in years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Alfred James</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lee Hatcher</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Shelma James - 910 N. Durham St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>RESPIRATORY failure</i> (B) CHRONIC OBSTRUCTIVE PUL. DIS. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>6/5/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>6/4</i> 19 <i>70</i> to <i>6/5</i> 19 <i>70</i> and that (2) (we) lost saw the deceased alive on <i>6/5</i> 19 <i>70</i> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James L. Bolen M.D.</i>		23B. PHYSICIAN'S NAME (Type) <i>JAMES L. BOLEN</i>		23C. DATE SIGNED <i>6/5/70</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/10/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>A. A. County Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Spencer E. Elison + 227 N. Caroline St.</i>		25D. ADDRESS			



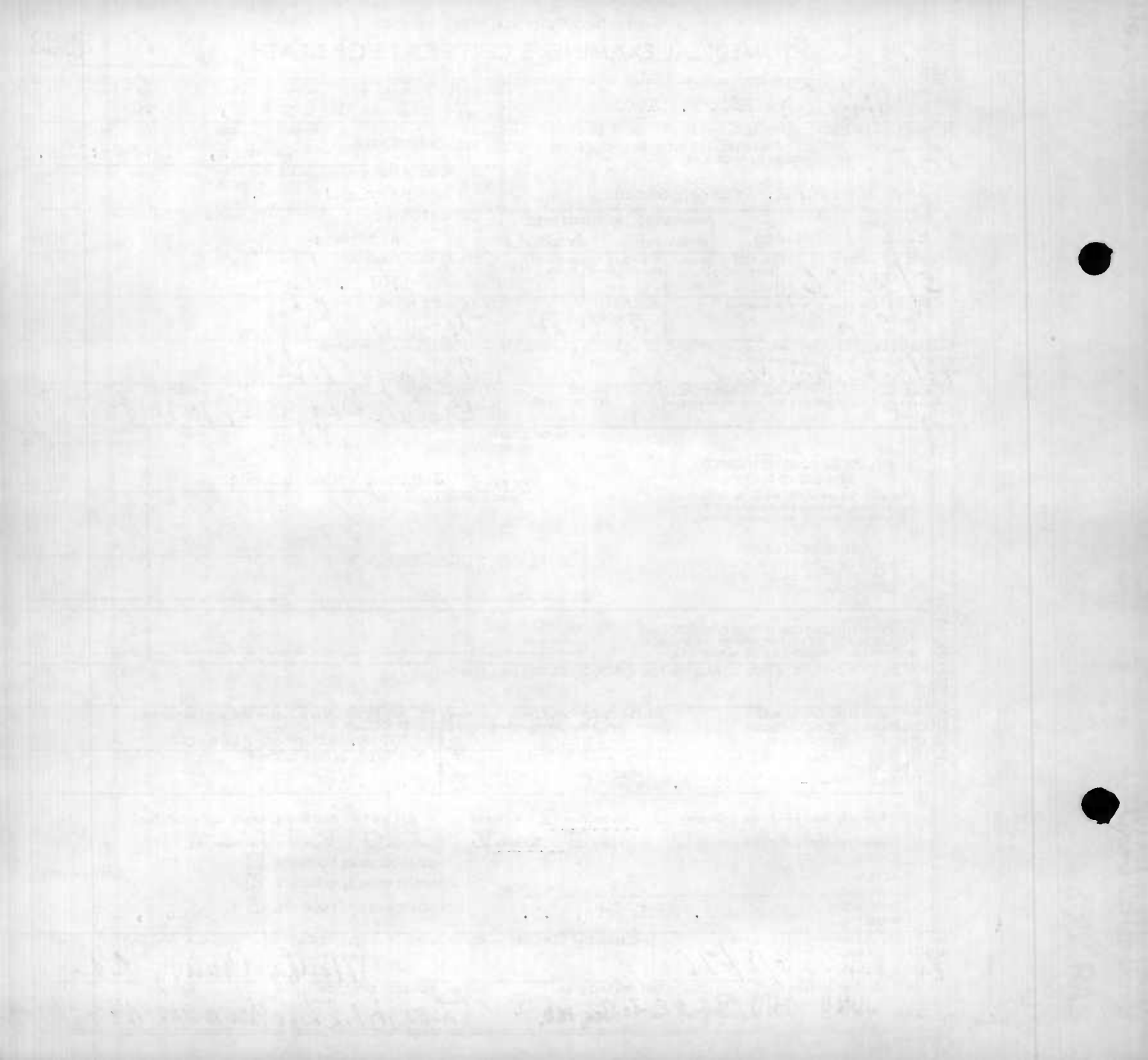
70 5833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5833

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(MORRIS) MAURICE F. DIGGS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>June 5, 1970</b>		Hour <b>M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1707 E. Preston Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>June 5, 1970</b>		Hour <b>6:35 A.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>5/8/06</b>		10. AGE (in years lost birthday) <b>64</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Diggs</b>		14. MOTHER'S MAIDEN NAME <b>Margie Mae</b>
15. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Retired - Steelworker</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Beatrice Diggs</b>		19. CAUSE OF DEATH <b>E955X</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Shotgun wound of chest</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>6-5-70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1707 E. Preston Street</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>6-5-70 6:12 A.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot self</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>June 5, 1970</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>6/8/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Matthew County, Va.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Laight E. Erickson</b> ADDRESS <b>2129 N. Parolme</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

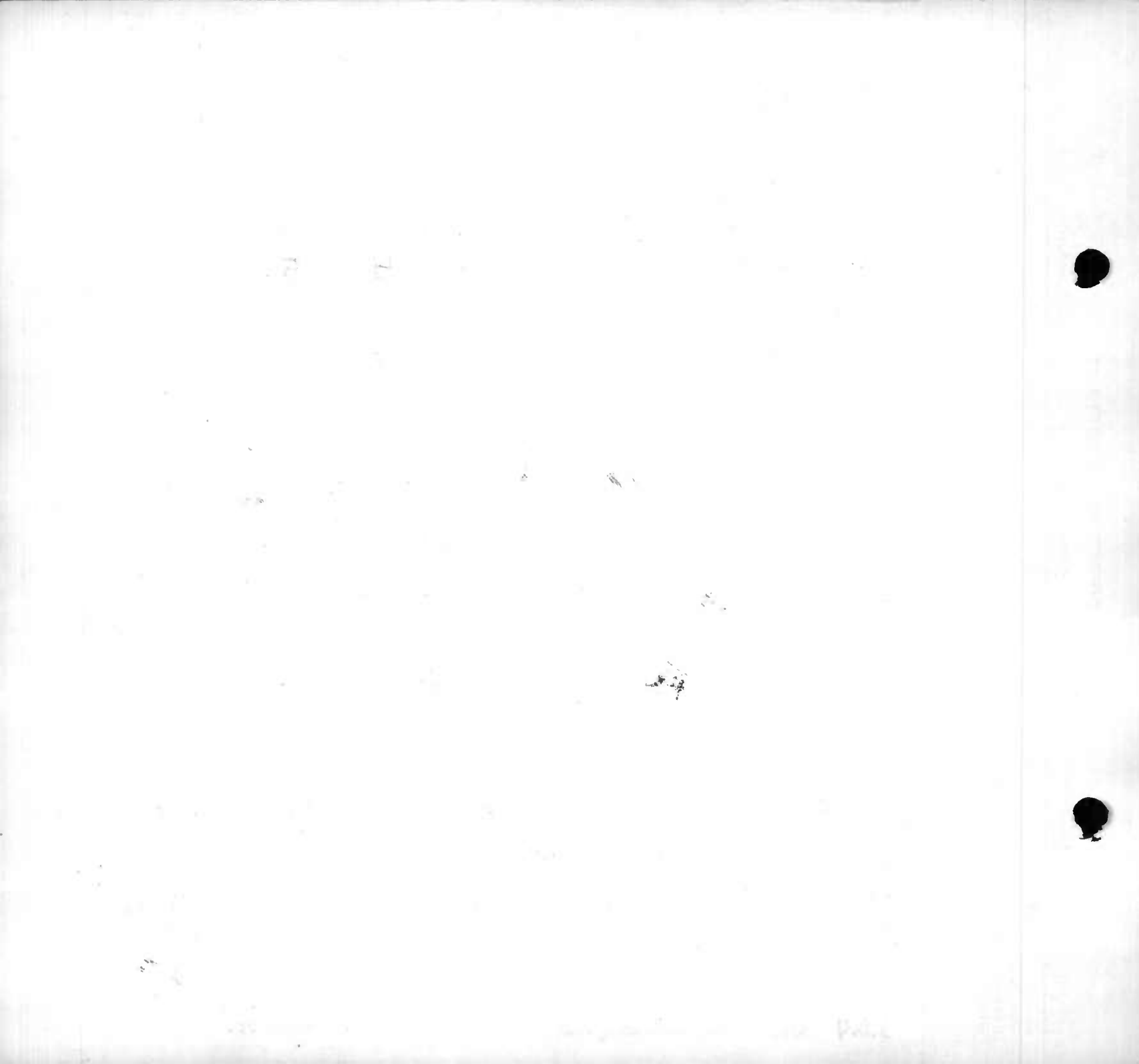
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5834	
BIRTH NO. 70 5834		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>John M. Boracki</b>		2. DATE AND HOUR OF DEATH <b>June 5, 1970 7:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>005410 Biddison Avenue</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>2734</b>	
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5410 Biddison Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27 1895</b>	9. AGE (In years last birthday) <b>74</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Batchman Can Co. Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jacob Boracki</b>		14. MOTHER'S MAIDEN NAME <b>Agusta Zuil Koska</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes War V</b>		16. SOCIAL SECURITY NO. <b>220-039274A</b>		17. INFORMANT <b>Mollie A. Boracki</b>	
18. <b>360.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Dehydration &amp; Vomits.</b> (B) <b>intestinal obstruction</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-31-69.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8-6-69</b> to <b>6-5-70</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>June 1</b> 19 <b>70</b> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. GROSSFELD, M.D.</b>		23B. DATE SIGNED <b>6-5-70</b>			
23C. PHYSICIAN'S NAME (Type) <b>5402 BELAIR RD</b>		23D. ADDRESS <b>5420 Belair Rd.</b>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>burial 6-9-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY CROSS CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>GERMAN HILL RD. Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Dippel Brothers Inc. 7110 Belair Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5835</u>
BIRTH NO. <u>70 5835</u>		70 5835 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>Emma Branch</u>		2. DATE AND HOUR OF DEATH <u>11:10 AM 6/6/70</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>9/2/14</u> 9. AGE (In years last birthday) <u>55</u>
13. FATHER'S NAME <u>LEE, RILEY</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>FANNIE ROBINSON</u>
17. INFORMANT <u>Johnnie Branch</u>		ADDRESS <u>2226 Mura St. 21213</u>		
18. <u>431.0</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory arrest</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary edema, hypertension</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Prob. intracerebral bleed</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>33</u> (this hospital) attended the deceased from <u>6/5</u> 19 <u>70</u> to <u>6/6</u> 19 <u>70</u> that <u>33</u> (we) last saw the deceased alive on <u>6/6</u> 19 <u>70</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>33</u> (We) (did) (not) view the body after death.				
23A. SIGNATURE <u>Loren G. Lipson, MD</u>				23B. DATE SIGNED <u>6/6/70</u>
23C. PHYSICIAN'S NAME (Type) <u>Loren G. Lipson, MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>transit-burial</u>		24B. DATE <u>6-10-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lee Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>1735 Harford Ave. Address 88213 Marshall W. Jones, Jr.</u>





70 5836

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 5836

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GAITHER SCOTT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>719 E. 22nd Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>June 3, 1970</b> Hour <b>8:15</b> P. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>908</b>	
9. DATE OF BIRTH <b>1-10-1941</b>		10. AGE (In years last birthday) <b>28</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Doctor Scott</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Ola M. Scott</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Ola M. Scott 719 E. 22nd St. 21218</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Sickle cell disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/4/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-6-1970</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Gaither, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		1735 Harford Ave. 21213	

Letter from M.E.'s office 6-16-70 M.H.

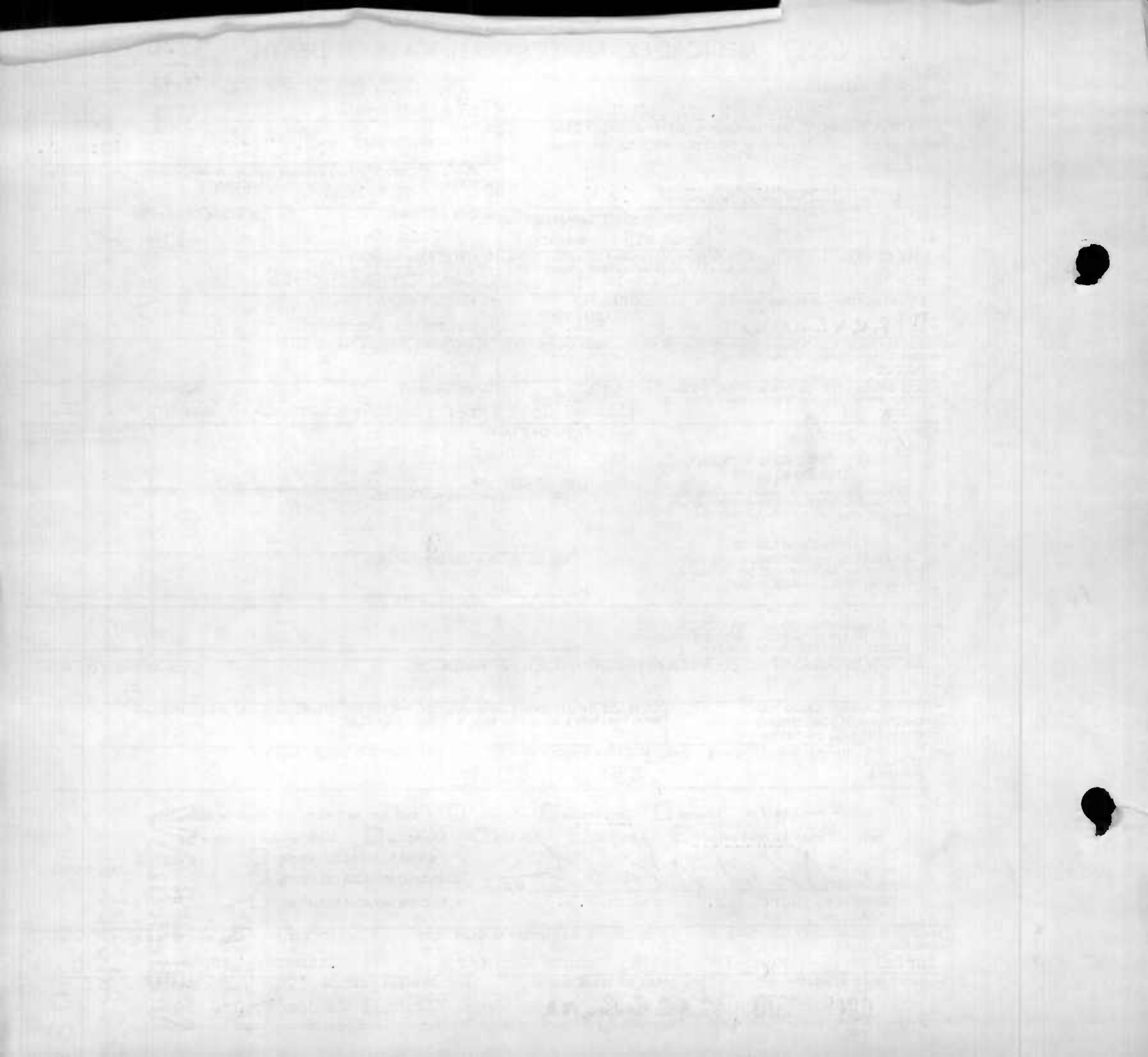
70 5837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5837

BIRTH NO.

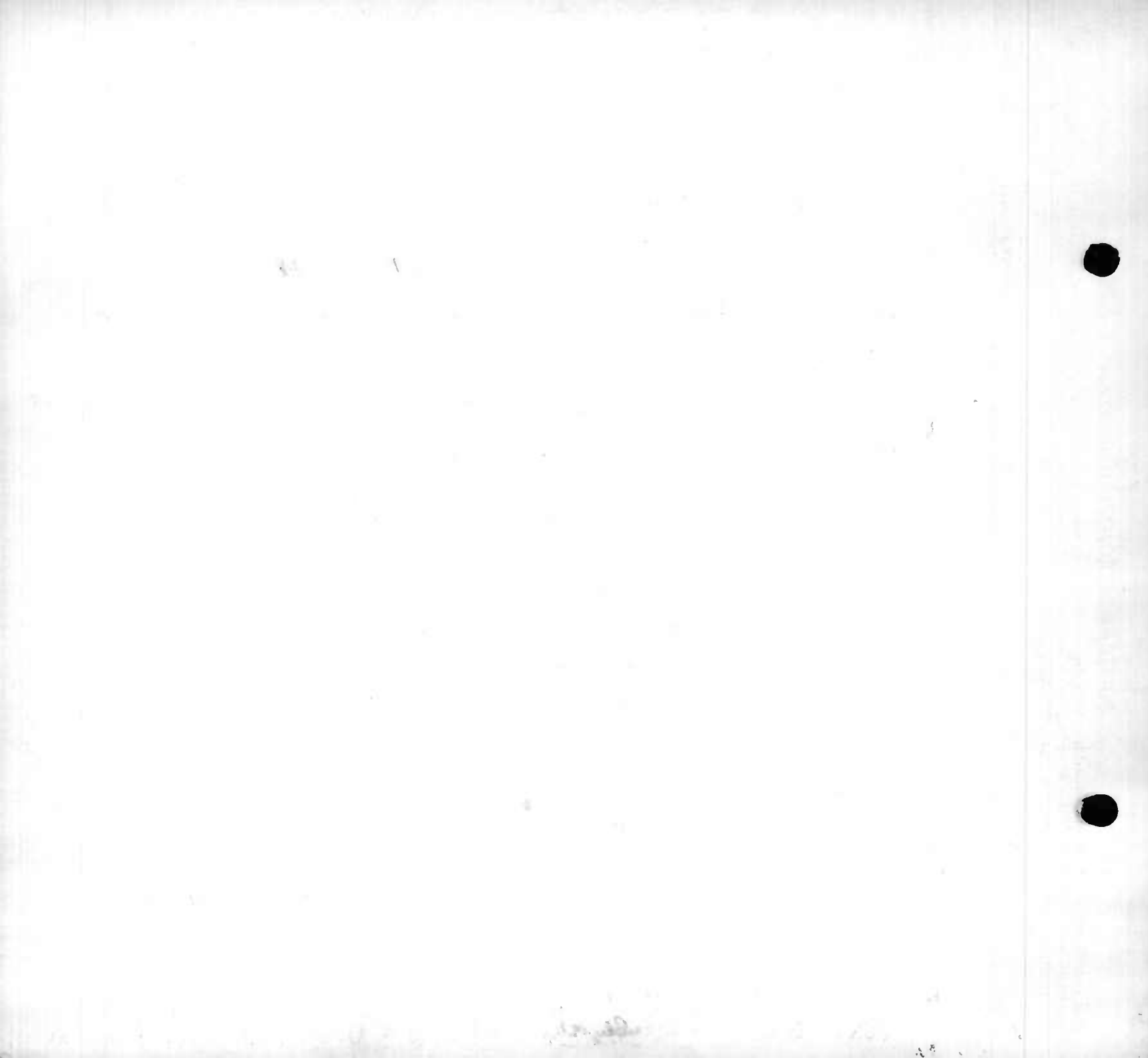
1. NAME OF DECEASED (Type or Print) <b>CLARENCE E. SAUNDERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>June 4, 1970 12:00 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 4, 1970 12:00 A.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>		C. CITY OR TOWN <b>Baltimore</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-23-02</b>		10. AGE (In years last birthday) <b>68</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawrence Saunders</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-07-3350</b>	
18. INFORMANT <b>Mrs. Viola Saunders</b>		ADDRESS <b>2402 Barclay ST. 21218</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I Carcinoma of Lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6/4/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-8-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213</b>		25D. NAME OF FUNERAL HOME <b>Marshall W. Jones, Jr.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

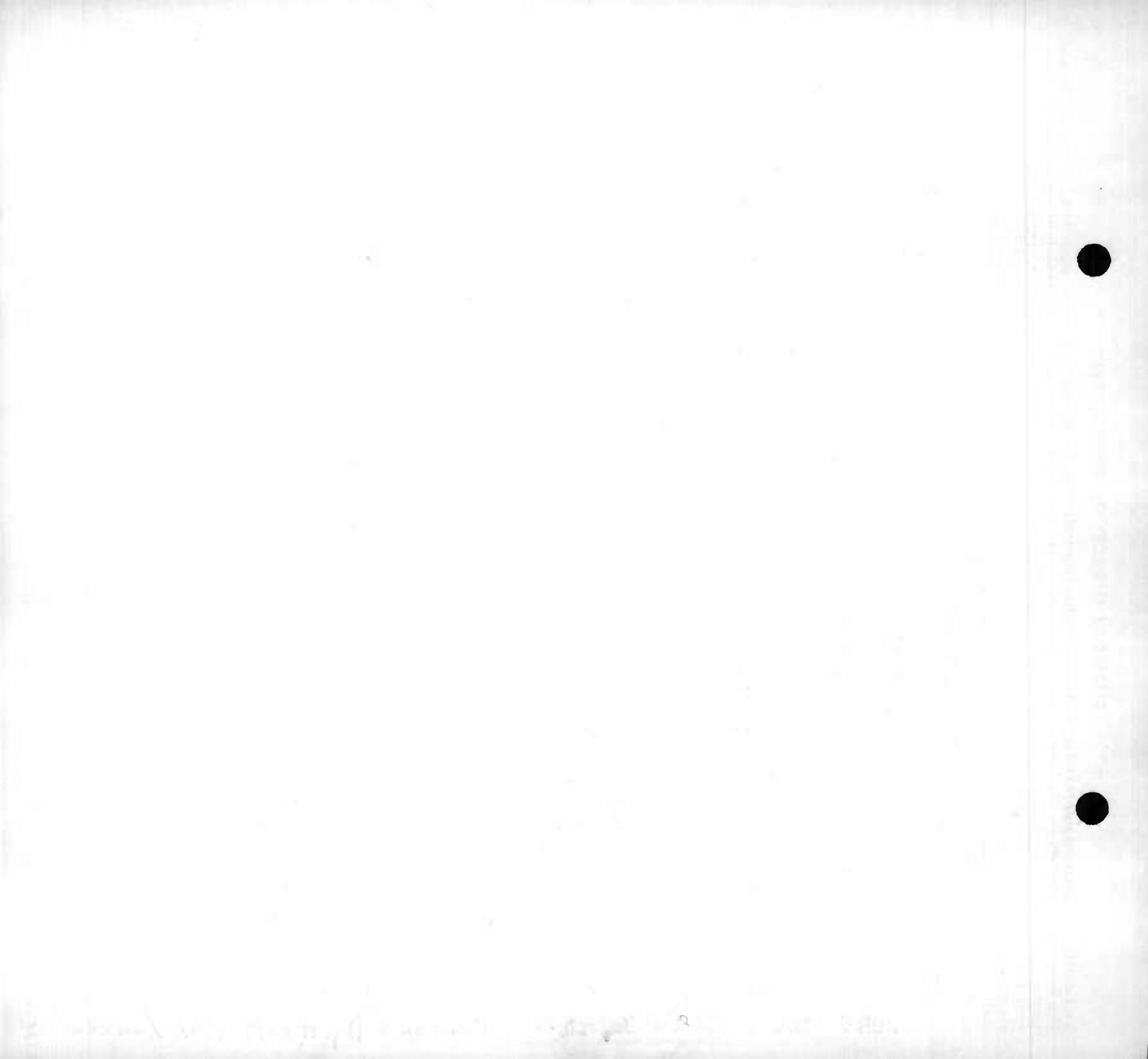
BALTIMORE CITY HEALTH DEPARTMENT				70 5838		REG. NO. 70 5838	
BIRTH NO.		70 5838		BIRTH NO.		70 5838	
1. NAME OF DECEASED (Type or Print) <b>MR SYLVESTER JOHNSON</b>				2. DATE AND HOUR OF DEATH <b>6/5/70 5 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 UNION MEMORIAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE & COUNTY <b>MARYLAND 2710</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL</b>				C. CITY OR TOWN <b>BALTIMORE 12</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>531 RICHWOOD AVE</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/21</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bob Davidson Ford</b>		11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SYLVESTER JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY JOHNSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>249-24-3958</b>		17. INFORMANT <b>MRS. IRENE JOHNSON</b>		ADDRESS <b>531 RICHWOOD AVE BALTIMORE MD.</b>	
18. <b>441.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Tamponade</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ruptured dissecting Aneurysm. Aortic Arch. (CS)</b>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>6/1</b> 19 <b>70</b> to <b>6/5</b> 19 <b>70</b> that (1) (we) lost saw the deceased alive on <b>6/5</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anne L. Liddy M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/5/70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6-9-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>		ADDRESS <b>1701 Laurens St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5839	
70 5839				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHILES JAMES Robert		2. DATE AND HOUR OF DEATH 6/4/70 8 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1-2710		C. CITY OR TOWN BALTIMORE 12	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP. 3330 CALVERT ST BALTO MD		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY ELECTRICIAN		8. DATE OF BIRTH 11-08-31	
13. FATHER'S NAME JOHN CHILES		14. MOTHER'S MAIDEN NAME ELIZABETH CLINKSCALE		9. AGE (in years last birthday) 38	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1952 KOREA		16. SOCIAL SECURITY NO. 219-28-2735		11. BIRTHPLACE (State or foreign country) MARYLAND, Balto.	
17. INFORMANT NURSE 3-11 PM. HALL 3 V.M.H.		ADDRESS		12. CITIZEN OF WHAT COUNTRY? AMERICAN (U.S.A.)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION DOCT-169 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Bladder 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE Metastatic Ca. Bladder DUE TO, OR AS A CONSEQUENCE OF: Ca. Bladder. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION DOCT-169		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Bladder		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/30 1970 to 6/4 1970 that (I) (we) last saw the deceased alive on 6/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. MEHTA MD		23B. DATE SIGNED 6/4/70		23C. PHYSICIAN'S NAME (Type) A. MEHTA MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/70		24C. NAME of CEMETERY or CREMATORY Balt. Nat'l Cem.	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR MORTON E. Dye & F. H. 1701 Laurens St.	
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (City, town, or county) Maryland		24F. LOCATION (City, town, or county) 21218	





5-363

70 5840

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 5840

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Willie Streeter

2. DATE AND HOUR OF DEATH

6/4/70

11:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)4940 Eastern Avenue  
Baltimore, Maryland 21224

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2765 Kinsey Ave 21223 007

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5/5/10

9. AGE (In years  
last birthday)

60

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Self-Employed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee, Wartace U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Willie Streeter

14. MOTHER'S MAIDEN NAME

Mattie Streeter

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

6. SOCIAL  
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH-Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic Ca of

liver

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3/6/70

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

obstructive jaundice

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐Work ☐At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/28 1970 to 6/4 1970  
that (I) (we) last saw the deceased alive on 6/4/70 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending ☐Med. ☐Staff ☒

23B. DATE SIGNED

6/4/70

23C. PHYSICIAN'S  
NAME (Type)

DIA2

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

DEGREE

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/8/70

24C. NAME of CEMETERY or CREMATORY

Western Star Cem.

24D. LOCATION

Catonsville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

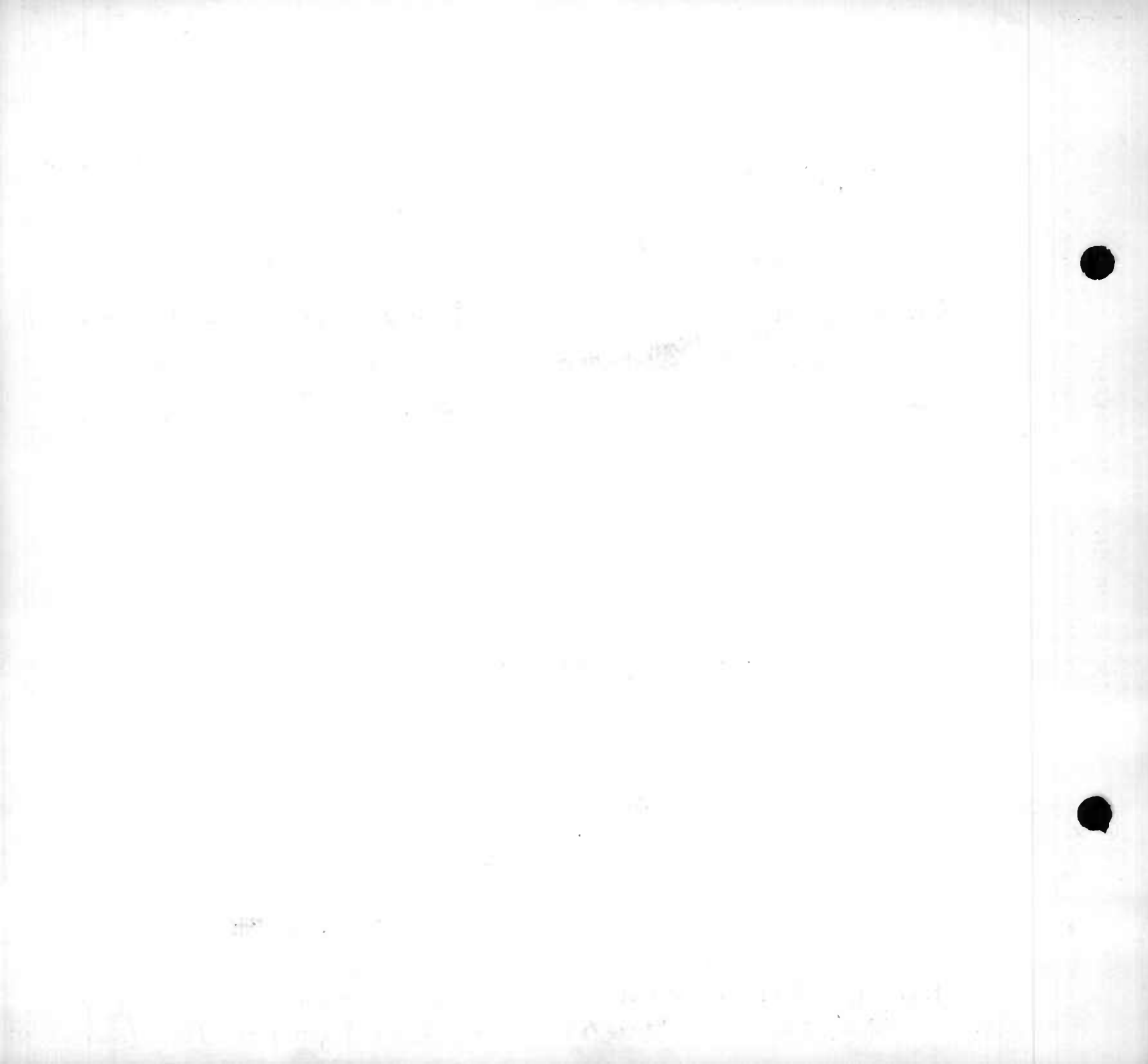
25C. FUNERAL DIRECTOR

Morton E. Dyett F.H. 1701 Laurens St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



70 5841

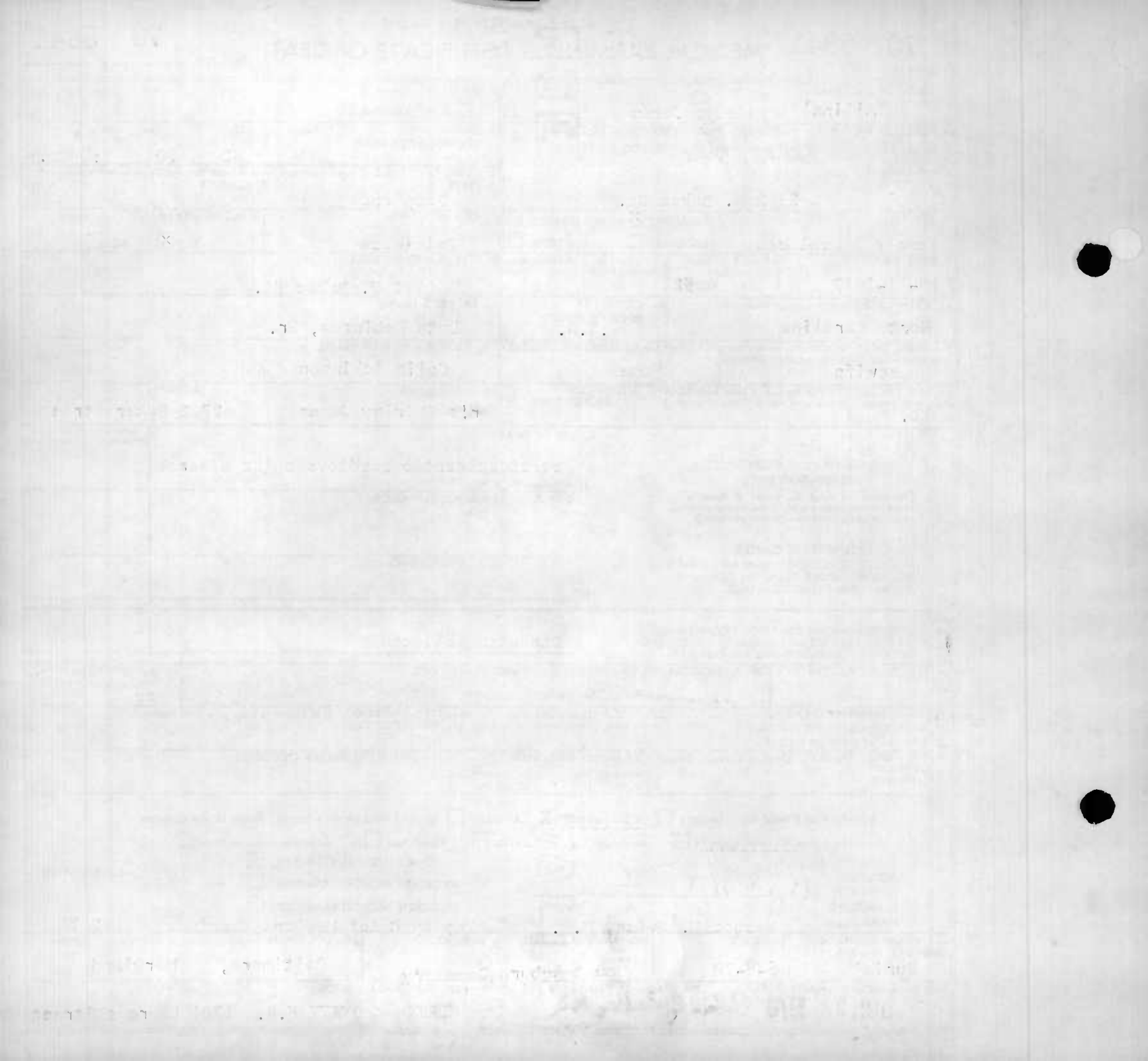
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5841

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(Alline) Filene James</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 2 70 8:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2702 W. Baker St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 2 70 8:00 a.m.	
6. SEX <b>female</b>		7. RACE <b>colored</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-11-1917</b>		10. AGE (In years lost birthday) <b>52</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO.	
16. INFORMANT <b>M's Shirley James</b>		ADDRESS <b>2702 Baker Street</b>	
19. CAUSE OF DEATH <b>412.44-250.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>no</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/2/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-8-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	



70 5842 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5842

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES HUSTON SCOTT

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ 6 6 70 11:33a M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)3. DATE PRONOUNCED DEAD Month Day Year Hour  
June 6, 1970 11:33 a.m.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

00 3610 Sequoia Ave.

Maryland

1511

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-14-1946

10. AGE (In years last birthday)

23

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3610 Sequoia Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Herman Bell

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Disable

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillian Miller

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No.

17. SOCIAL SECURITY NO.

18. INFORMANT

Mrs. Lillian Bailey

ADDRESS

3610 Sequoia Avenue

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Intravenous narcotism  
DUE TO, OR AS A CONSEQUENCE OFAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)  
Burial

24B. DATE

6-9-70

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State)

Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens Street

ADDRESS

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X

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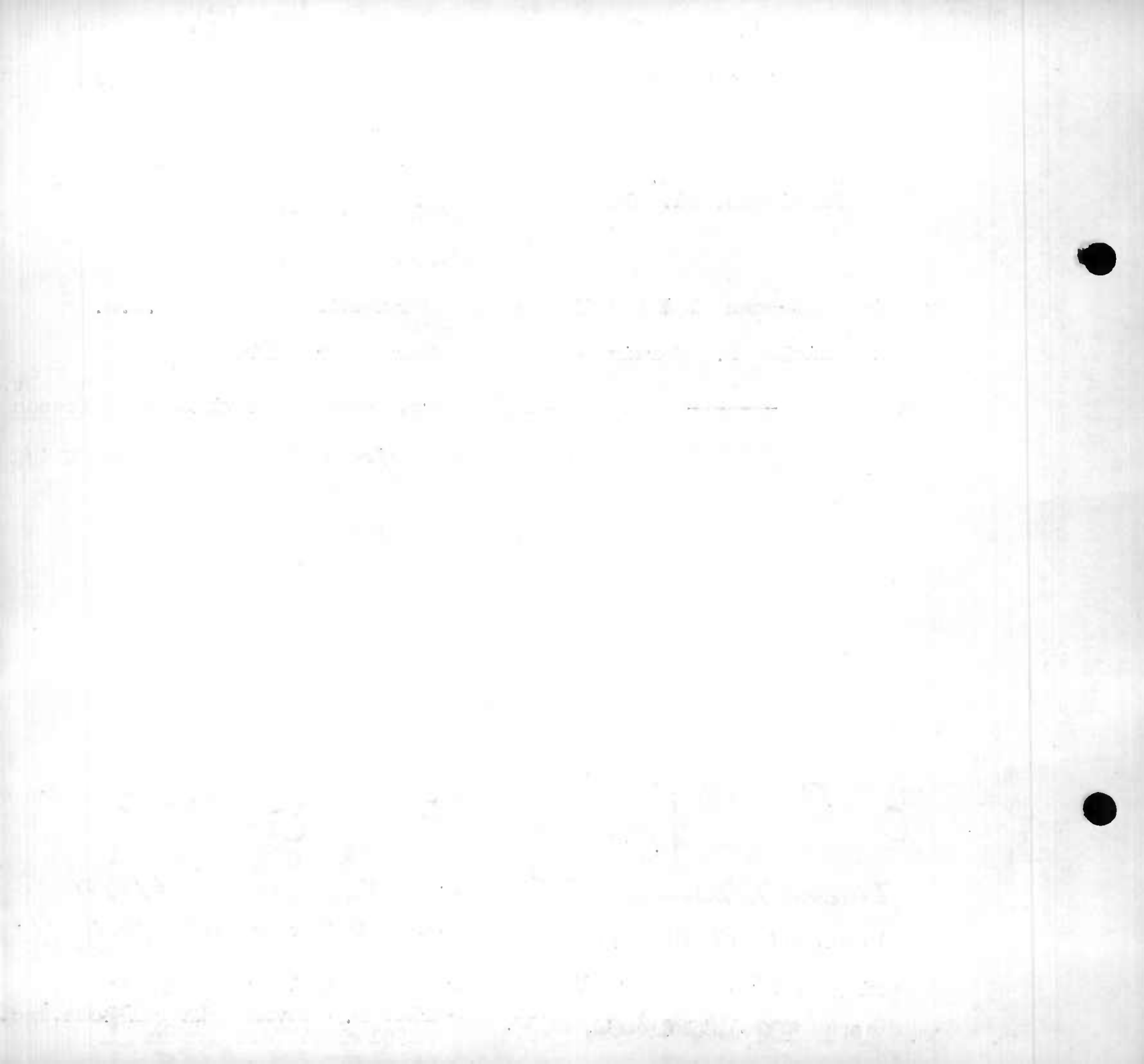
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 5843		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5843	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Winfield C. Martin</b>			2. DATE AND HOUR OF DEATH <b>June 5, 1970 10:40 p M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2401</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1441 Towson St. Baltimore, Md. 21230</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1441 Towson St.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/6/92</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crossing Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Winfield S. Martin</b>			14. MOTHER'S MAIDEN NAME <b>Mary Franklin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-2529R</b>		17. INFORMANT ADDRESS <b>Mrs. Martha Langville 1441 Towson St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Carcinoma of Right Lung</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6/2/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 6 1970</b> to <b>June 5 1970</b> , that (I) (we) last saw the deceased alive on <b>June 5 1970</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vincent M. Messina M.D.</b>				23B. DATE SIGNED <b>6/8/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Vincent M. Messina</b>				23D. ADDRESS <b>1403 S. Charles St. Balto. Md. 21234</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/9/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc.</b>	
				ADDRESS <b>1501 East Fort Avenue</b>	

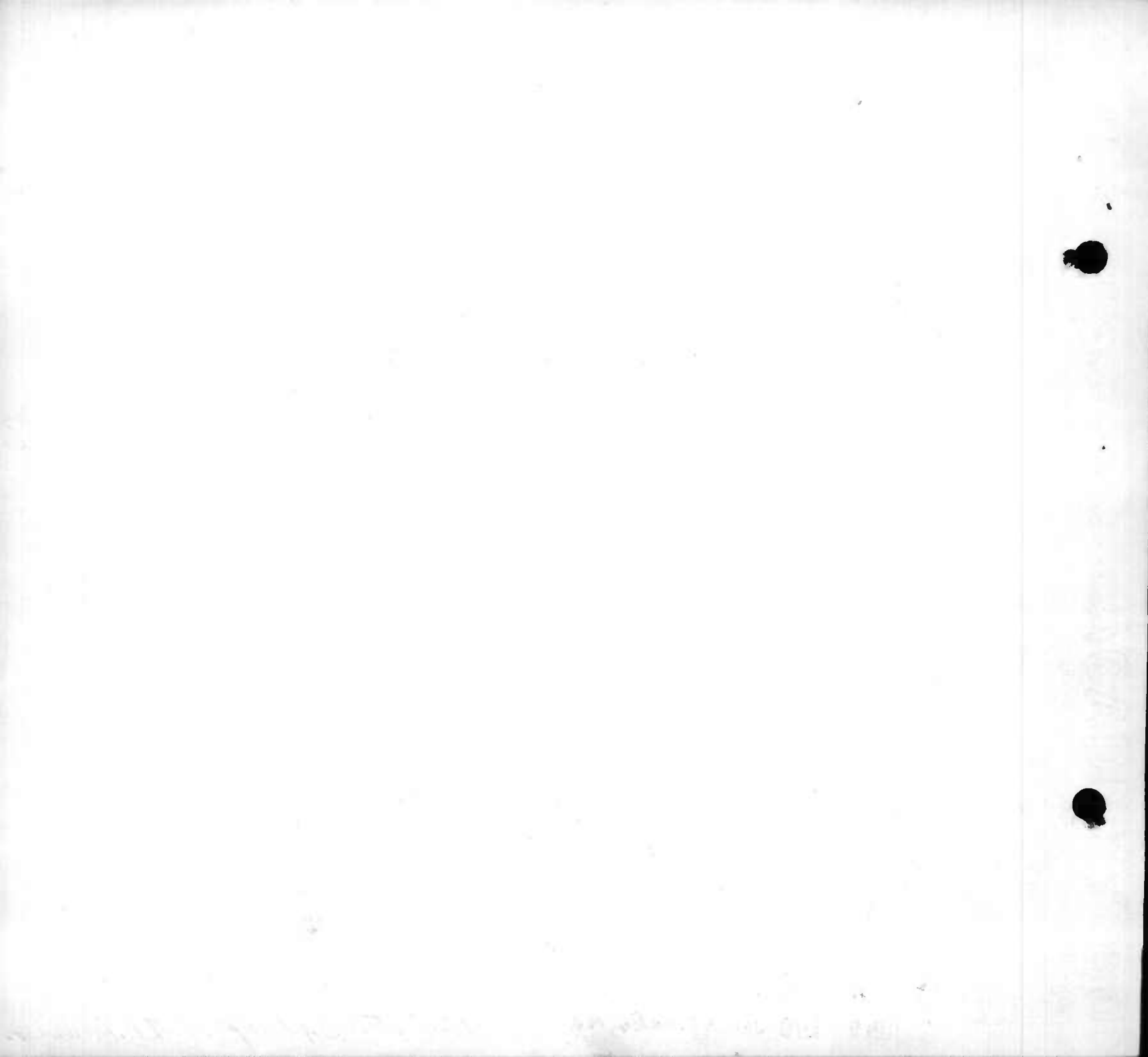




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-630		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5844	
BIRTH NO.		70 5844		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		FRANCIS W. TRUETT (WILLIAMS)		2. DATE AND HOUR OF DEATH 4 JUN 4 1970 8:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland Baltimore 1512		5. STREET AND NUMBER 2507 Shirley Avenue	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-04	9. AGE (In years lost birthday) 65	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME George A. Williams Sr.		14. MOTHER'S MAIDEN NAME Nellie Davis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George A. Williams 2038 Harlan Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic CA of Lung 8mo (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jun 3 1970 to Jun 4 1970 that (I) (we) last saw the deceased alive on Jun 4 1970 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carol L. Roski MD		23B. DATE SIGNED 6/4/70		23C. PHYSICIAN'S NAME (Type) Carol L. Roski MD	
23D. ADDRESS Univ. of Md Hospital		23E. FUNERAL DIRECTOR Washington Phillips 1727 N. Mount St.		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 9 1970		24F. NAME OF REGISTRAR Robert E. J. J. J.	



K-530

70 5845

BALTIMORE CITY HEALTH DEPARTMENT

70 5845

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEROY KENNEDY

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF DECEASED  
IF NOT A HOSPITAL OR LAST PLACE OF RESIDENCE  
OR INSTITUTION

00 931 Leadenhall (vacant house)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

June

4,

1970

7:05 P.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

1512

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Aug. 26, 1939

10. AGE (In years  
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3732 Reisterstown Rd.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Edward Kennedy Kennedy

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Farmer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen Branchette

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

216-34-3003

18. INFORMANT

Kennedy  
Alice Kennedy

ADDRESS

Same

19.

304.71

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Intravenous narcotism

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

7

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 5, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/8/70

24C. NAME OF CEMETERY or CREMATORY

Archives Mem. Ch.

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Washington Phillips 1722 N. Menard St.

ADDRESS

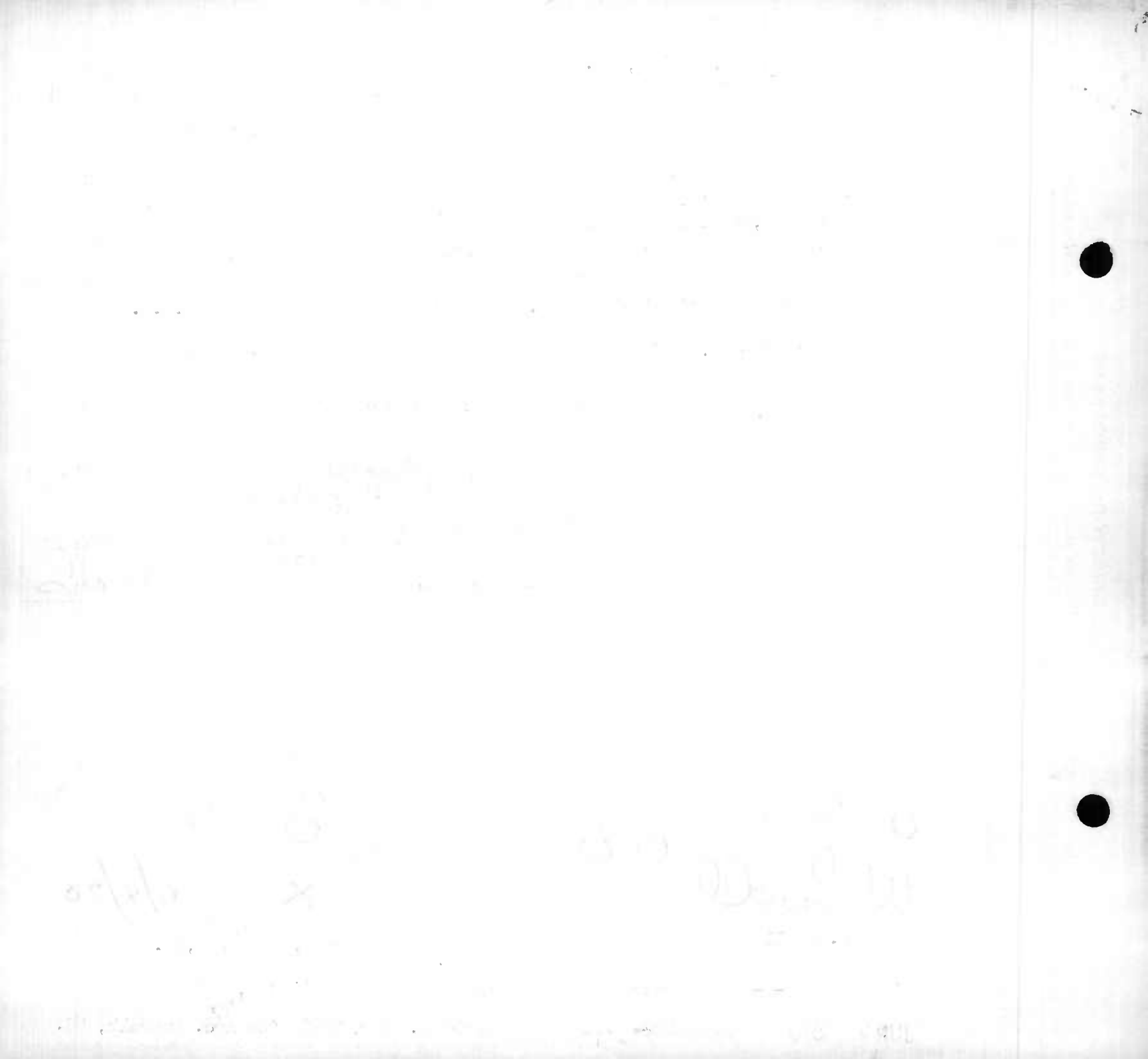
Letter from M.E.'s office 7-14-70 M.H.  
V.S. 153 7-27-70 M.H.

P.460

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

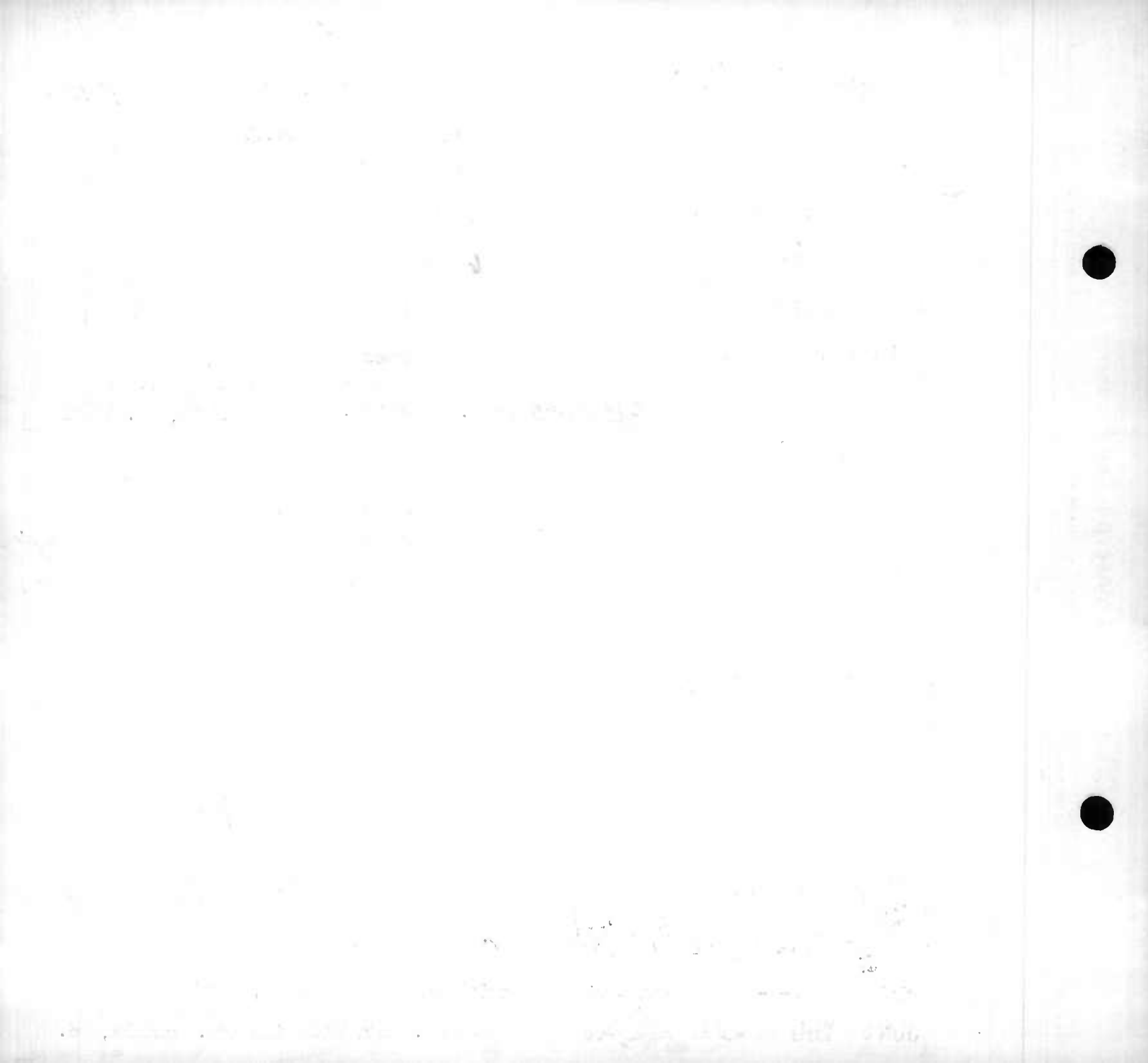
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5846	
BIRTH NO. 70 5846		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Hubert G. Puller, Sr.		2. DATE AND HOUR OF DEATH 6/4/70 9:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY Baltimore	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 842 Jaydee Avenue		21222			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1902	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Stieff Silver Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME William T. Puller			
14. MOTHER'S MAIDEN NAME Mary E. Fletcher		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 218-01-4159		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Hypoxia		1-2 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF: Hypotension.			
ANTECEDENT CAUSES		(B) Acute Renal Failure		5 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF: Hypotension			
(C) Pneumonia				8 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5/16 1970 to 6/4 1970 that (II) (we) last saw the deceased alive on 6/4 1970 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Lowell		23B. DATE SIGNED 6/4/70		23C. PHYSICIAN'S NAME (Type) W. Lowell	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6-8-70		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		30 5847		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		70 5847	
1. NAME OF DECEASED (Type or Print) <b>HENRIETTA E. HUSSEY</b>				2. DATE AND HOUR OF DEATH <b>6-4-70 1:10 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? <b>BALTO.</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1931 QUENTIN RD.</b>							
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-14-15</b>		9. AGE (In years last birthday) <b>54</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANK L. CORK</b>				14. MOTHER'S MAIDEN NAME <b>Agnes S. ZELLER</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-01-0522</b>		17. INFORMANT (Husband) <b>Mr. Russell E. Hussey</b> ADDRESS <b>1931 Quentin Road Dundalk, Md. 21222</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic &amp; renal failure</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Due to, or as a consequence of: Cirrhosis of liver &amp; Portal Hypertension &amp; renal failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic &amp; renal failure</b> (C) <b>HPN + recurrent bleeding esophageal varices</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>5-6-70</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PORTAL HPN</b>				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-1</b> 19 <b>70</b> to <b>June 4</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>June 4</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Cesar A. Lopez M.D.</b>				23B. DATE SIGNED <b>June 4, 1970</b>				23C. PHYSICIAN'S NAME (Type) <b>CEZAR A. LOPEZ M.D.</b>			
23D. ADDRESS <b>CHURCH HOME &amp; Hosp.</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-8-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park</b>				24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>				25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			





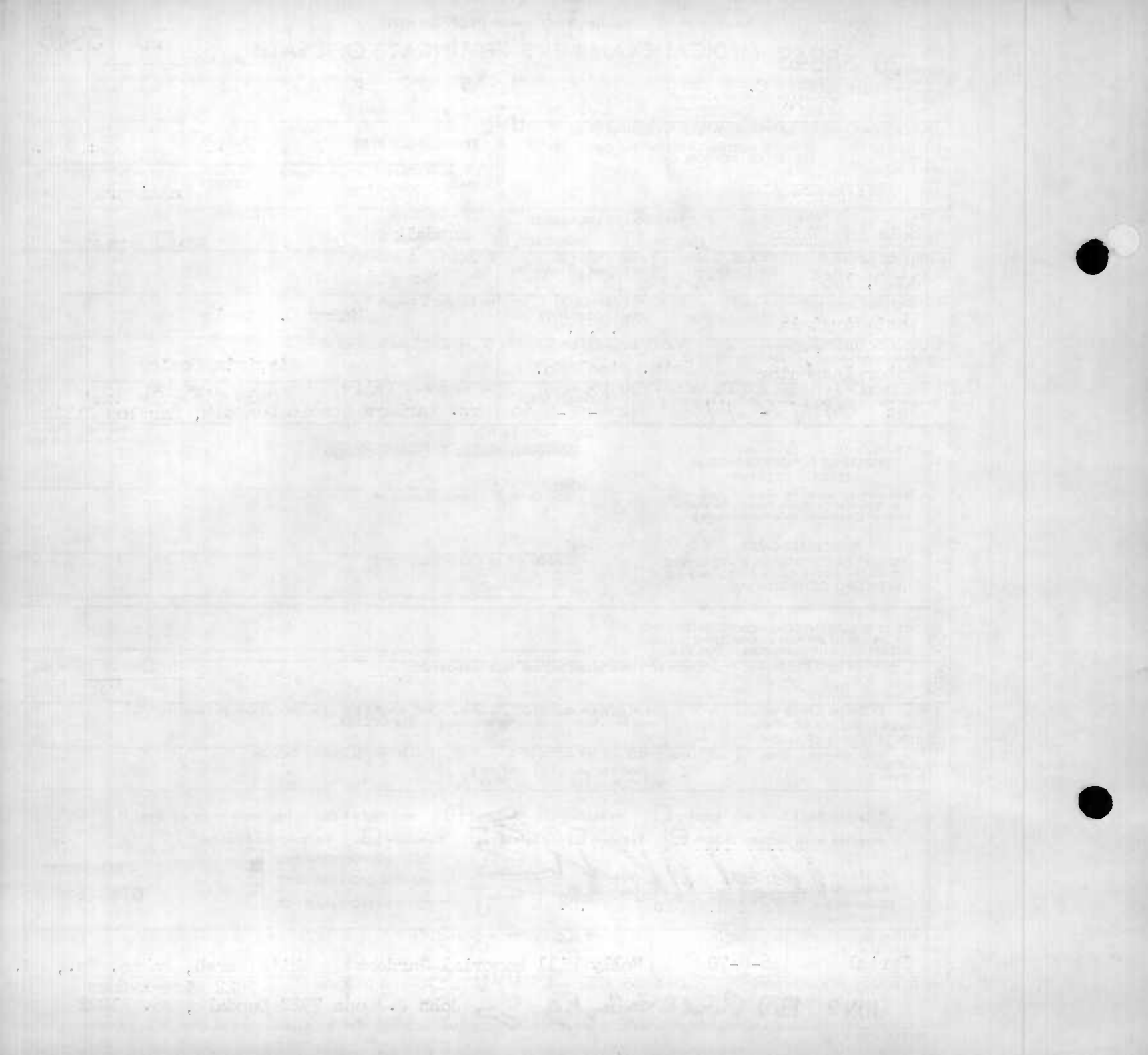
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 5848

BIRTH NO. 70 5848

REG. NO.

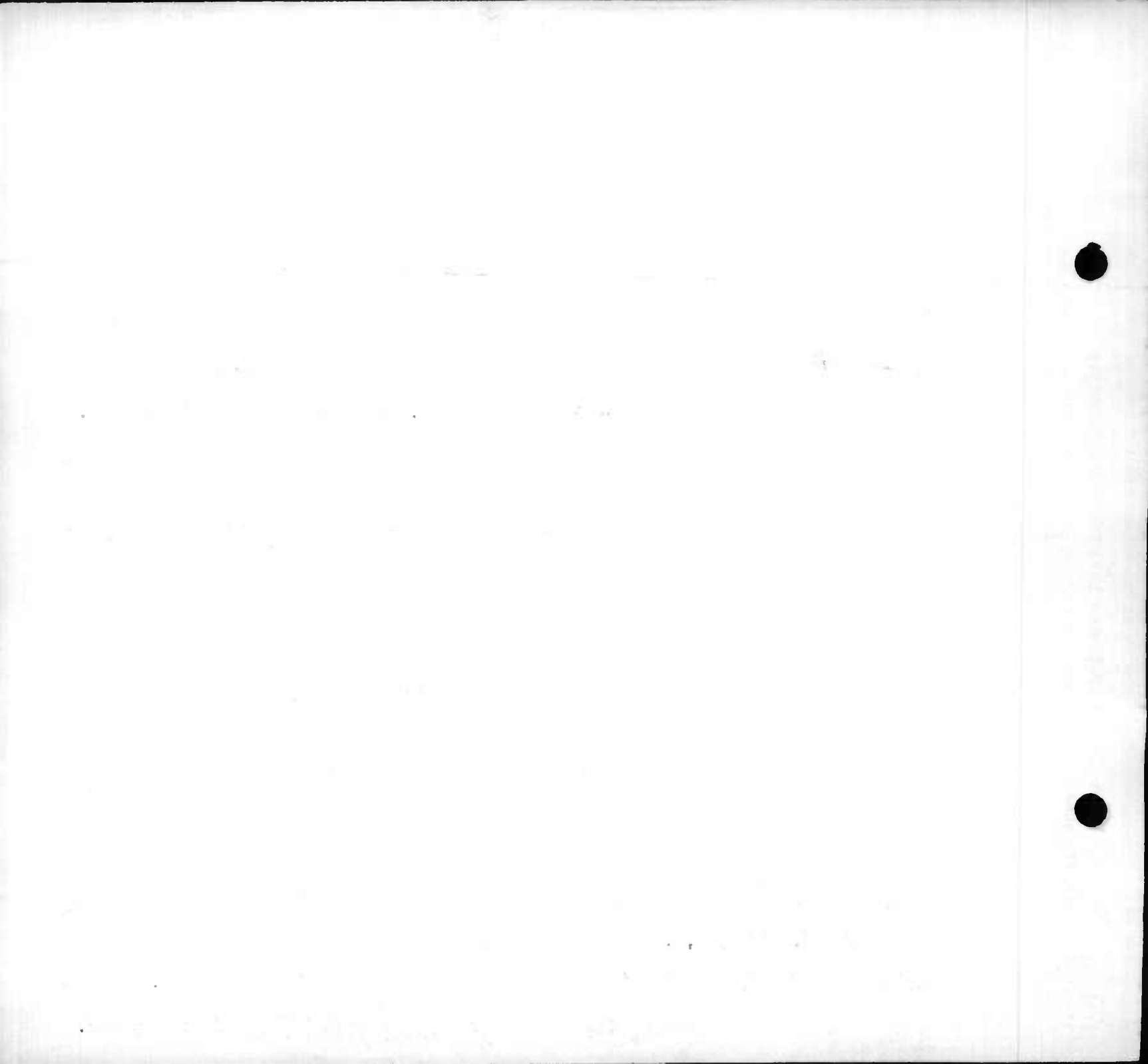
1. NAME OF DECEASED (Type or Print) NORMAN STEELE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 3, 1970 2:30 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Dundalk
9. DATE OF BIRTH May 3, 1936		10. AGE (in years lost birthday) 34	E. STREET AND NUMBER 8014 Kimberly Road
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Harry C. Steele
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Inspector		14B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	15. MOTHER'S MAIDEN NAME Virginia Bosley
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/16/56-2/4/58		17. SOCIAL SECURITY NO. 234-58-2139	18. INFORMANT (Wife) ADDRESS Mrs. Barbara Steele Dundalk, Maryland 21222
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 431.9 Intracerebral Hemorrhage		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/4/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-6-70	24C. NAME of CEMETERY or CREMATORY Holly Hill Memorial Gardens	24D. LOCATION (City, town, or county) (State) White Marsh, Balto. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970	25B. NAME OF REGISTRAR Robert E. Faber, M.D.	25C. FUNERAL DIRECTOR John J. Duda	ADDRESS 7922 Wise Avenue Dundalk, Md. 21222



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 5849		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5849	
1. NAME OF DECEASED (Type or Print) <b>MINNIE A WILKINS</b>				2. DATE AND HOUR OF DEATH <b>6-2-70 1655 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Ugmd. Hospital</b> <b>38 BALTIMORE MD</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>DELAWARE</b> B. COUNTY <b>SELBYVILLE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Ugmd. Hospital</b>				C. CITY OR TOWN <b>SELBYVILLE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>NEG</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-8-15</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Law</b>				14. MOTHER'S MAIDEN NAME <b>Lou Show</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-09-5356</b>		17. INFORMANT <b>Jerry L. Wilkins</b>		ADDRESS <b>Selbyville, Dela.</b>	
18. I <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY Embolus</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CA of Breast c metastasis</b> (B) <b>1965</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>STAT</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-31-70</b> 19 to <b>6-2</b> 19 <b>70</b> and that (I) (we) last saw the deceased alive on <b>6-1</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel H. White, M.D.</b>				23B. DATE SIGNED <b>6-2-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Daniel H. White, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>6/6/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Long's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Selbyville, Sussex Co., Delaware</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Richard E. Taylor, R.A.</b>		25C. FUNERAL DIRECTOR <b>Richard J. Watson</b>		ADDRESS <b>Millsboro, Del.</b>	



YINGLING, JR RALPH C.  
02 17 39

## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 5850	
BIRTH NO. 1-524		70 5850		1. NAME OF DECEASED (Type or Print) YINGLING JR. RALPH C.		2. DATE AND HOUR OF DEATH 6-6-70 4/40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21074 CARROLL CO. 5600			
FULL NAME OF HOSPITAL OR INSTITUTION 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN HAMPSTEAD		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 117 HILLCREST ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/39		9. AGE (In years last birthday) 31	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Wayne Feed Co.		11. BIRTHPLACE (State or foreign country) Baltimore County Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH C. Yingling, Sr.				14. MOTHER'S MAIDEN NAME HELEN NAYLOR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-36-7596		17. INFORMANT Wanda Yingling		ADDRESS 117 Hillcrest St. Hampstead, Md. 21074	
18. 757.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH WITH ELECTRO- (A) IMMEDIATE CAUSE RENAL FAILURE LYTE IMBALANCE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE 2° TO AORTIC ROOT ANEURISM (B) DUE TO, OR AS A CONSEQUENCE OF: MARFAN'S SYNDROME (C) PULMONARY EMBOLUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 4 YEARS 31 YEARS 4 WEEKS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 5/9 1970 to 6/4 1970 that (H) (we) last saw the deceased alive on 6/4 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Dennis W. Blakely M.D.				23B. DATE SIGNED 6/6/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) DENNIS W. BLAKELY M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/70		24C. NAME of CEMETERY or CREMATORY Kriders Cemetery		24D. LOCATION (City, town, or county) (State) Westminster Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR John E. Goff		ADDRESS Hampstead, Md. 21074	

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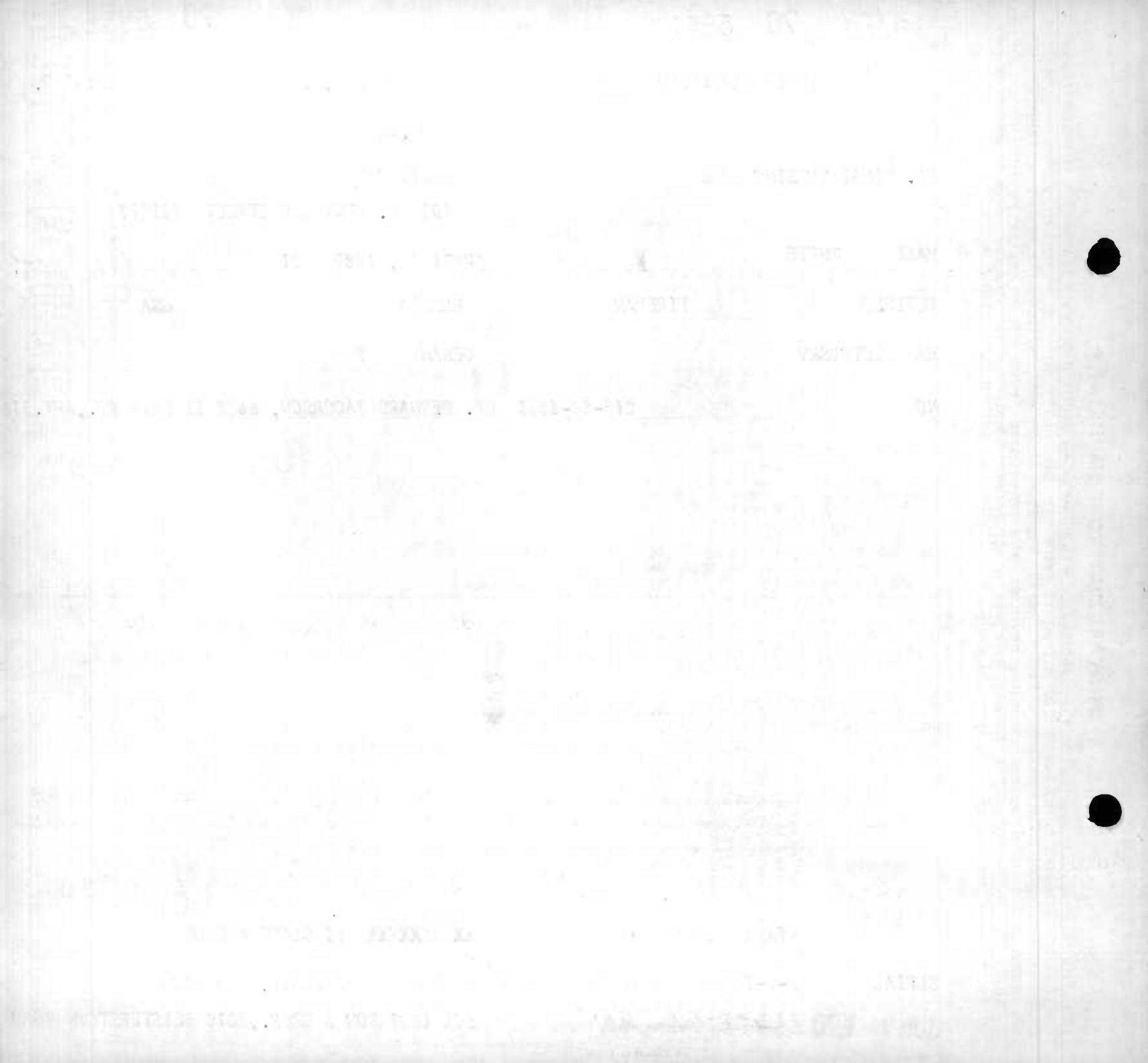
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5851</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-431 70 5851</span> <span style="font-size: 1.5em;">1</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <span style="font-size: 1.2em;">LOUIS SLOTOVSKY</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <span><span style="font-size: 1.2em;">JUNE 4, 1970</span></span> <span><span style="font-size: 1.2em;">3:45 P.M.</span></span> </div> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">MT. SINAI NURSING HOME</span> <span style="font-size: 1.5em;">90</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2030 N. BENTALOU STREET #21217</span>		
<b>5. SEX</b> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	<b>6. RACE</b> WHITE <input checked="" type="checkbox"/> BLACK <input type="checkbox"/> OTHER <input type="checkbox"/>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">APRIL 15, 1889</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">81</span>	<b>10. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">RETIRED</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">FIREMAN</span>		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">RUSSIA</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">MAX SLOTOVSKY</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">DENAH ?</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">219-20-8331</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MR. BERNARD JACOBSON, 6800 LIBERTY RD., APT. 316</span>			<b>ADDRESS</b> <span style="font-size: 1.2em;">MR. BERNARD JACOBSON, 6800 LIBERTY RD., APT. 316</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div> <b>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div> <b>18B. IMMEDIATE CAUSE</b>            DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">Acute</span> </div> <div> <b>18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>  <span style="font-size: 1.2em;">Broncho pneumonia</span> </div> </div>					
<b>19. DATE OF OPERATION</b> <span style="font-size: 1.2em;">6-4-70</span>					
<b>20. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">2 wks</span>					
<b>21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>					
<b>22. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">11-1 1961 to 6-4 1970</span>					
<b>23. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">ROSEDALE, MARYLAND</span>					
<b>24. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">6-4-70</span>					
<b>25. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
<b>26. HOW DID INJURY OCCUR?</b> <span style="font-size: 1.2em;">11-1 1961 to 6-4 1970</span>					
<b>27. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">11-1 1961</span> <b>to</b> <span style="font-size: 1.2em;">6-4 1970</span> <b>that (I) (we) lost</b> <span style="font-size: 1.2em;">6-4 1970</span> <b>and that in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">6-4 1970</span> <b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>28. SIGNATURE</b> <span style="font-size: 1.2em;">Stanley Steinbach MD</span>					
<b>29. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">STANLEY STEINBACH</span>					
<b>30. ADDRESS</b> <span style="font-size: 1.2em;">11 SLADE AVENUE</span>					
<b>31. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">BURIAL</span>					
<b>32. DATE</b> <span style="font-size: 1.2em;">6-7-70</span>					
<b>33. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">BETH JACOB ANSHE VESHEAR</span>					
<b>34. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">ROSEDALE, MARYLAND</span>					
<b>35. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 9 1970</span>					
<b>36. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, MD</span>					
<b>37. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>					

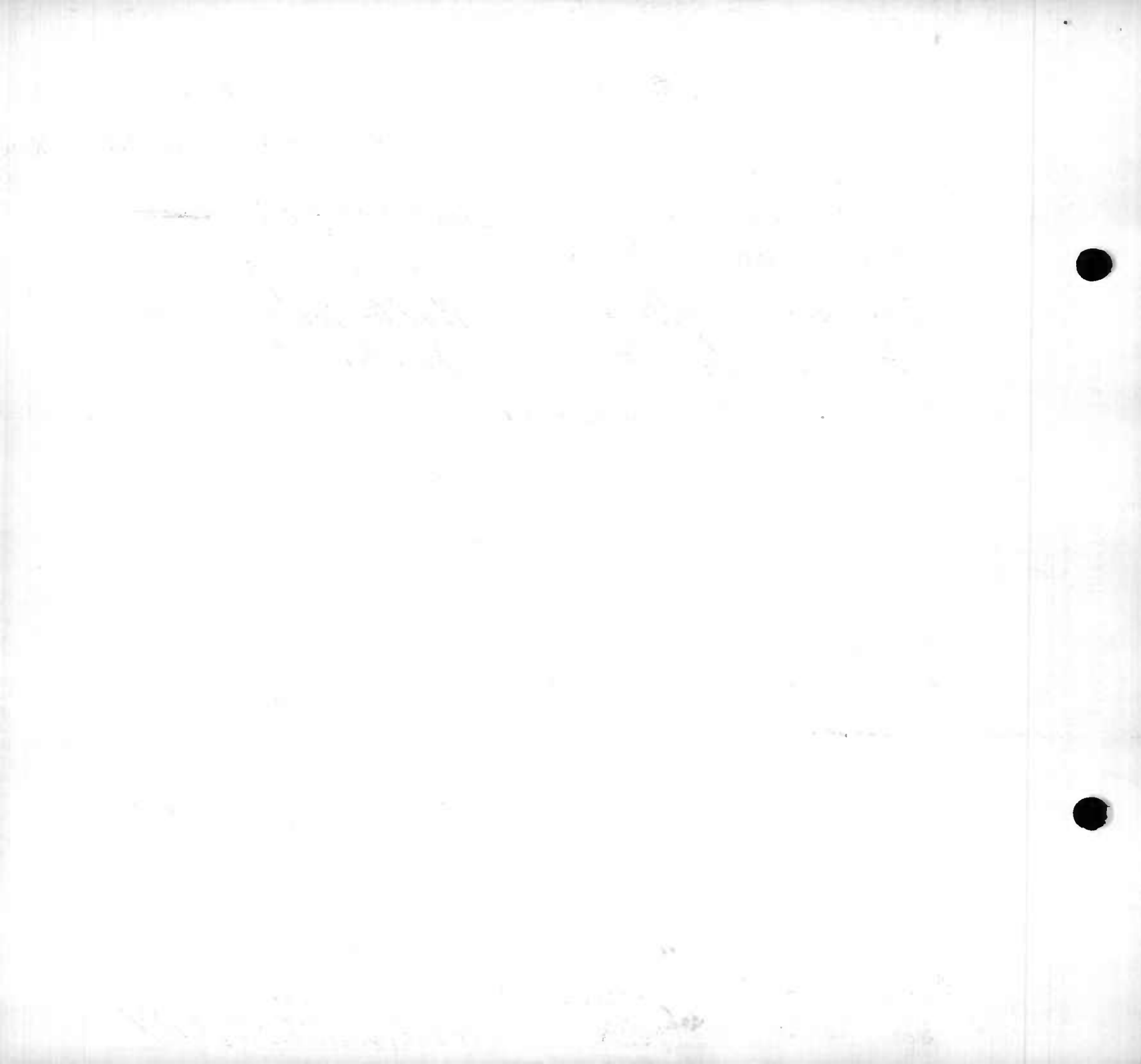




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

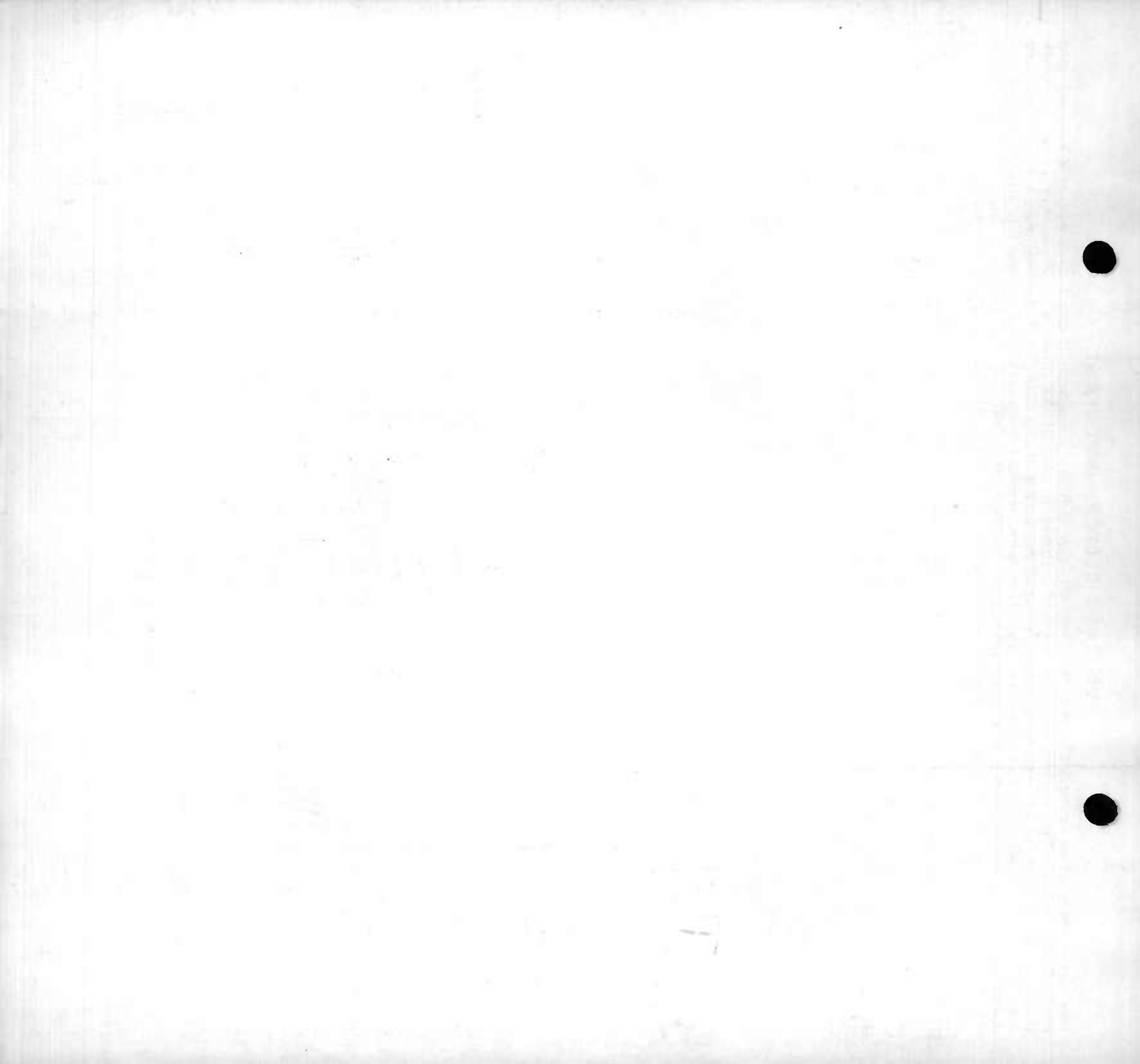
<div style="display: flex; justify-content: space-between;"> <span>70 5852</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>70 5852</u>	
BIRTH NO. <u>S-530</u>		1. NAME OF DECEASED (Type or Print) <u>IRVIN SMITH</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>428 Sinai Hospital of Baltimore</u> <u>Baltimore, Md. 21215</u>		2. DATE AND HOUR OF DEATH <u>June 6, 1970 10:40 A.M.</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>XXXXXX</u> B. COUNTY <u>XXXXXX</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/26/16</u> 9. AGE (In years last birthday) <u>53</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>office</u>	
11. BIRTHPLACE (State or foreign country) <u>Balt., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mollie ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES <u>W.W II ARMY -</u>		16. SOCIAL SECURITY NO. <u>219-10-5561</u>	
17. INFORMANT <u>Gloria Smith</u>		ADDRESS <u>same</u>	
18. <u>151.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Stomach</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>4/14/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer Stomach</u>	
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>70</u> to <u>6/6</u> 19 <u>70</u> . that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Kantorn Kriyayakirana</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>KANTORN KRITAYAKIRANA</u> DEGREE		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/7/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Chapel Amundson</u>		24D. LOCATION (City, town, or county) <u>Balt., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u>		ADDRESS <u>6000 Beist Rd.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

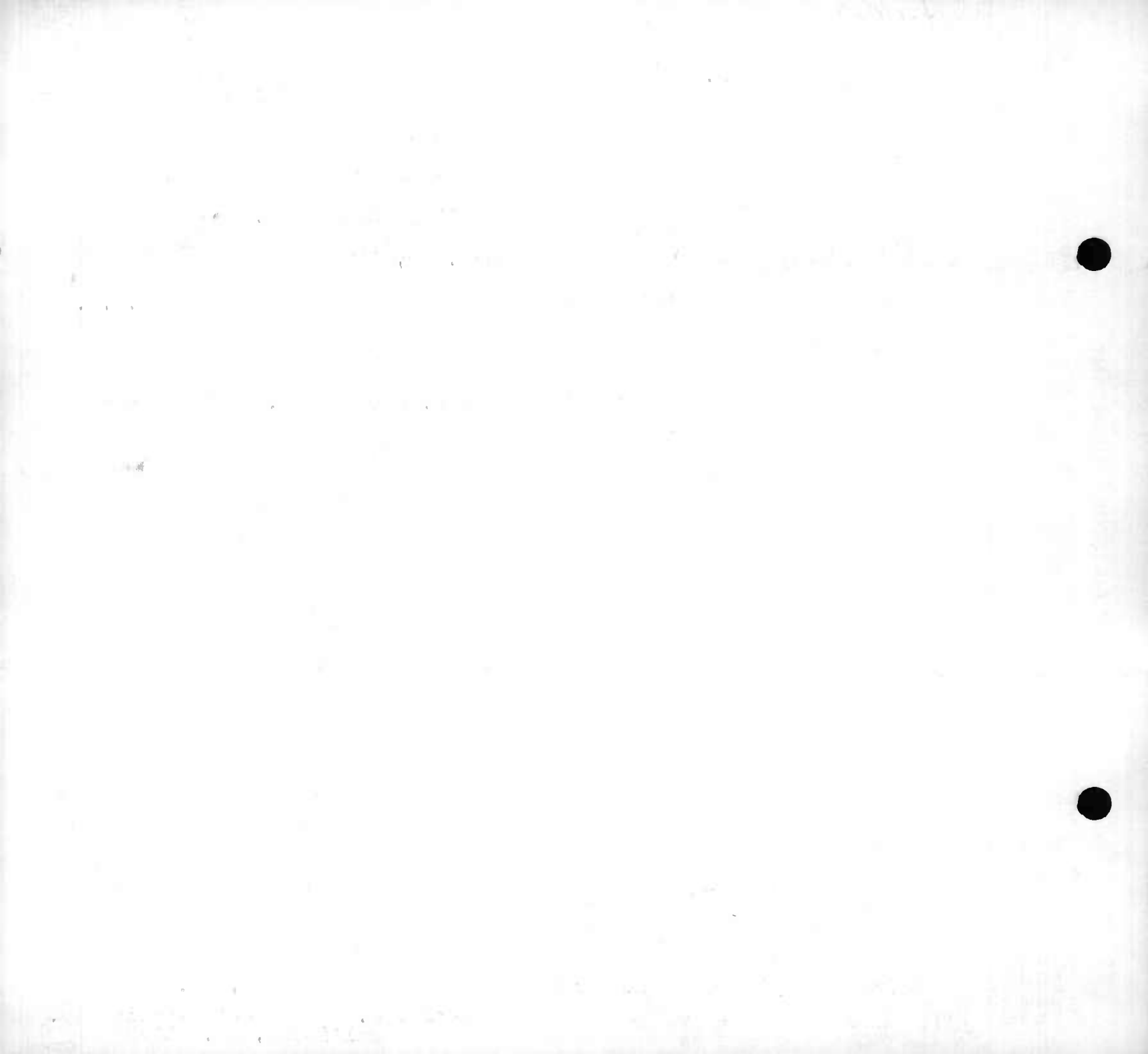
<div style="display: flex; justify-content: space-between;"> <span>0-65570 5853</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>70 5853</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		Registered No. <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	
BIRTH NO. <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> M.E. CASE NO. <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em; margin-left: 50px;">ORMAN</span> <span style="font-size: 1.5em; margin-left: 50px;">ETHEL</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em; margin-left: 50px;">6-4-1970</span> <span style="font-size: 1.5em; margin-left: 50px;">9-15A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em; margin-top: 10px;">Maryland General Hospital</span>  <span style="font-size: 1.5em; margin-top: 5px;">Baltimore</span> </div> <div style="width: 50%;">           (If not in hospital or institution, give street address or location)         </div> </div>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.5em; margin-left: 50px;">MD</span> B. COUNTY <span style="font-size: 1.5em; margin-left: 50px;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em; margin-left: 50px;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em; margin-left: 50px;">1607 St. Paul St.</span>	
5. SEX <span style="font-size: 1.5em; margin-top: 5px;">FEMALE</span>	6. RACE <span style="font-size: 1.5em; margin-top: 5px;">CAUCASIAN</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em; margin-top: 5px;">WIDOWED</span>	8. DATE OF BIRTH <span style="font-size: 1.5em; margin-left: 50px;">2-4-1923</span> <span style="font-size: 1.5em; margin-left: 50px;">AGE (In years last birthday) 47</span> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em; margin-top: 5px;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em; margin-top: 5px;">OWN HOME</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em; margin-top: 5px;">UNKNOWN</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em; margin-top: 5px;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em; margin-top: 5px;">UNKNOWN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em; margin-top: 5px;">UNKNOWN</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em; margin-top: 5px;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em; margin-top: 5px;">213-20-0551</span>	
17. INFORMANT <span style="font-size: 1.5em; margin-top: 5px;">EDWARD STANLEY</span>		ADDRESS <span style="font-size: 1.5em; margin-top: 5px;">3420 16th N.W. Wash, D.C. 20000</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.5em; margin-left: 50px;">Pneumococcal Pneumonia</span> (B) DUE TO <span style="font-size: 1.5em; margin-left: 50px;">Dehydration</span> (C)	
19A. DATE OF OPERATION <span style="font-size: 1.5em; margin-top: 5px;">—</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em; margin-top: 5px;">—</span>	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em; margin-top: 5px;">NO</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em; margin-left: 50px;">6-4-1970</span> to <span style="font-size: 1.5em; margin-left: 50px;">6-4-1970</span> and that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em; margin-left: 50px;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em; margin-top: 5px;">Fateh</span>		23B. DATE SIGNED <span style="font-size: 1.5em; margin-top: 5px;">6-4-1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em; margin-top: 5px;">M. FATEH</span>		23D. ADDRESS <span style="font-size: 1.5em; margin-top: 5px;">MD. Cen. Hosp.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em; margin-top: 5px;">Burial</span>		24B. DATE <span style="font-size: 1.5em; margin-top: 5px;">6-8-70</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em; margin-top: 5px;">Loudon Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em; margin-top: 5px;">BALTIMORE MD.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em; margin-top: 5px;">JUN 9 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em; margin-top: 5px;">Robert E. Taylor, Jr.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.5em; margin-top: 5px;">Wm. Cook Brooks Towson, Inc.</span>		ADDRESS <span style="font-size: 1.5em; margin-top: 5px;">Towson, Md.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

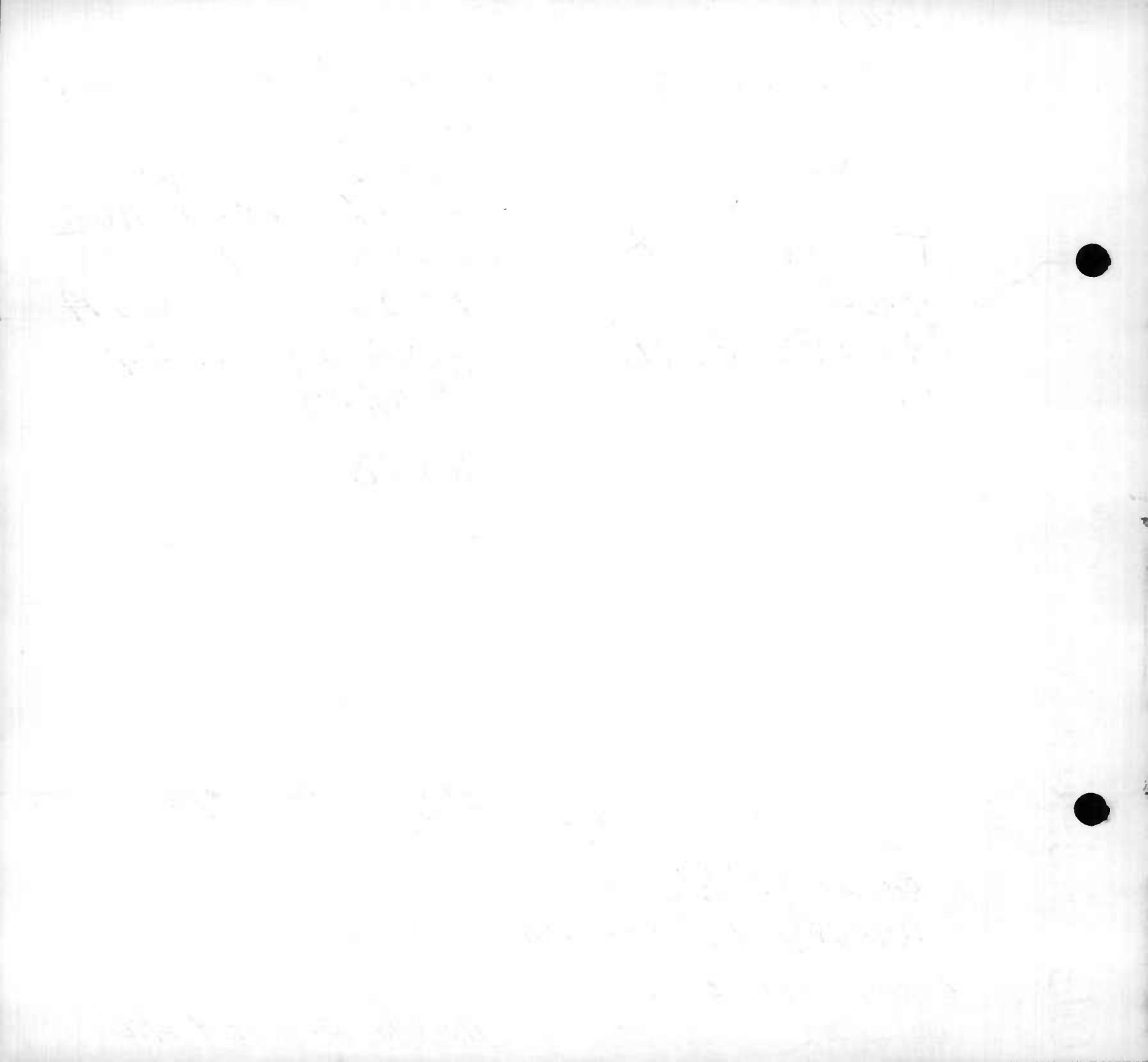
H-400 70 5854		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5854	
1. NAME OF DECEASED (Type or Print) <b>JOHN P. HULL</b>			2. DATE AND HOUR OF DEATH <b>6/6/70 11:12 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2403</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1273 William St.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1911</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Municipal Court</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Hull</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Reily</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 01 2801</b>		17. INFORMANT <b>Mrs. Margaret D. Hull</b>	
18. I <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction Complicated by Shock, Tachycardia, Fibrillation</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY (Yes or No)</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		
MEDICAL CERTIFICATION					
22. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>6-5-1970</b> to <b>6-6-1970</b> that <del>(s)</del> (we) last saw the deceased alive on <b>6-6-1970</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>(has)</del> (did not) view the body after death.					
23A. SIGNATURE <b>George J. Gonce</b>			23B. DATE SIGNED <b>6-6-70</b>		23C. PHYSICIAN'S NAME (Type) <b>KAYANI L. MANGLONIA</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6/10/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>			25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>
25D. ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-540		70 5855		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5855	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CATHERINE R. CONLEY				2. DATE AND HOUR OF DEATH 6/6/70 7:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEM HOSP				A. STATE MD		B. COUNTY BALTO	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3201 ROSEKEMP AVE			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/6/08	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSEW				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CHARLES BAILEY				14. MOTHER'S MAIDEN NAME ROSE MURPHEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-07-8870		17. INFORMANT CHART	
18. CAUSE OF DEATH 712.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/6 1970 to 6/6 1970 that (I) (we) last saw the deceased alive on 6/6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey B. Sher MD				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HARVEY B. SHER MD	
23D. ADDRESS UMH		23E. DEGREE		23F. ADDRESS			
24A. BURNAL CREMATION, REMOVAL (Specify)		24B. DATE 6/10/70		24C. NAME OF CEMETERY OR CREMATORY Linden Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Gable, MD		25C. FUNERAL DIRECTOR McGill		25D. ADDRESS 130 E. Feet Ave.	





1

70 5856

BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 70 5856

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **WALTER KRULIKOWSKI**

2. DATE OF DEATH  
Known ☐ Month Day Year Hour  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
**38 University Hospital**

3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
**6 7 1970 4:07 A.M.**

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE **Md.** B. COUNTY **1203**

6. SEX **Male** 7. RACE **White** 8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH **May 27 1914** 10. AGE (In years last birthday) **56** 11. Under 1 Yr. 12. Under 24 Hrs. Months Days Hours Min.  
E. STREET AND NUMBER **2617 N. Calvert St.**

11. BIRTHPLACE (State or foreign country) **Perth Amboy, N.J.** 12. CITIZEN OF WHAT COUNTRY? **USA** 13. FATHER'S NAME **John Krulikowski**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 14B. KIND OF BUSINESS OR INDUSTRY **General Cable Corp** 15. MOTHER'S MAIDEN NAME **Nellie Wisniewski**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 17. SOCIAL SECURITY NO. 18. INFORMANT **Bertha Krulikowski** ADDRESS **50 McGuire St. Woodridge N.J.**

19. **E81911** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
(A) IMMEDIATE CAUSE **Cranio-cerebral inj. with fracture of neck**  
DUE TO, OR AS A CONSEQUENCE OF:  
(B)   
DUE TO, OR AS A CONSEQUENCE OF:  
(C)   
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION **5-30-70** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **street** 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? **State Rt. 25 Intersection Beckleysville Rd**

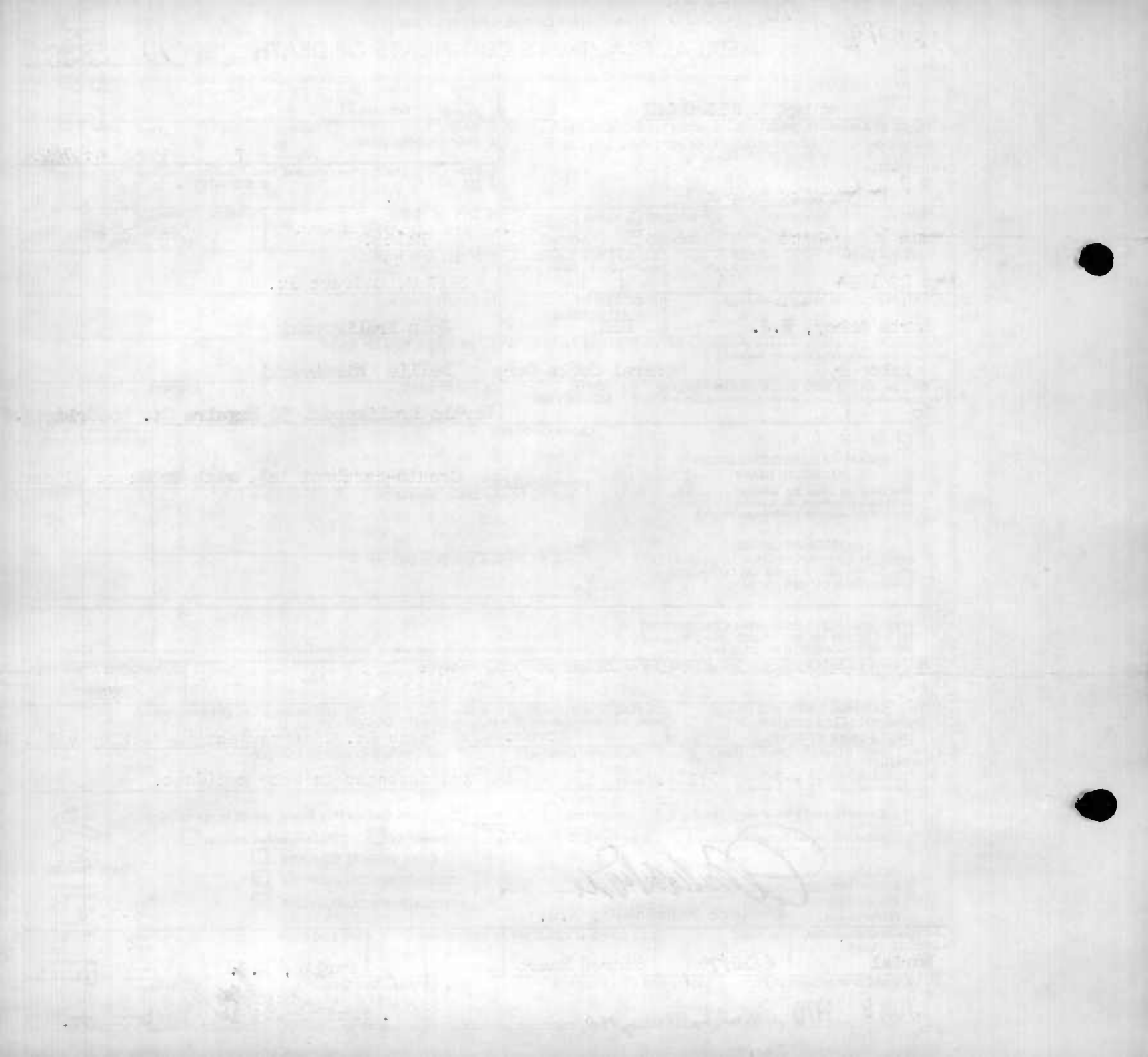
22D. TIME OF INJURY (APPROX.) **5-30-70 7:30A.M.** 22E. INJURY OCCURRED. WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? **Passenger in auto accident.**

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE **Isidore Mihalakis, M.D.** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **6-7-70**  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **6/10/70** 24C. NAME OF CEMETERY or CREMATORY **Sacred Heart Cemetery** 24D. LOCATION (City, town, or county) (State) **Parlin, N.J.**

25A. DATE REC'D BY HEALTH DEPT. **JUN 9 1970** 25B. NAME OF REGISTRAR **Robert E. [Signature]** 25C. FUNERAL DIRECTOR **James E. Bruzdinski** ADDRESS **1407 Eastern Ave.**

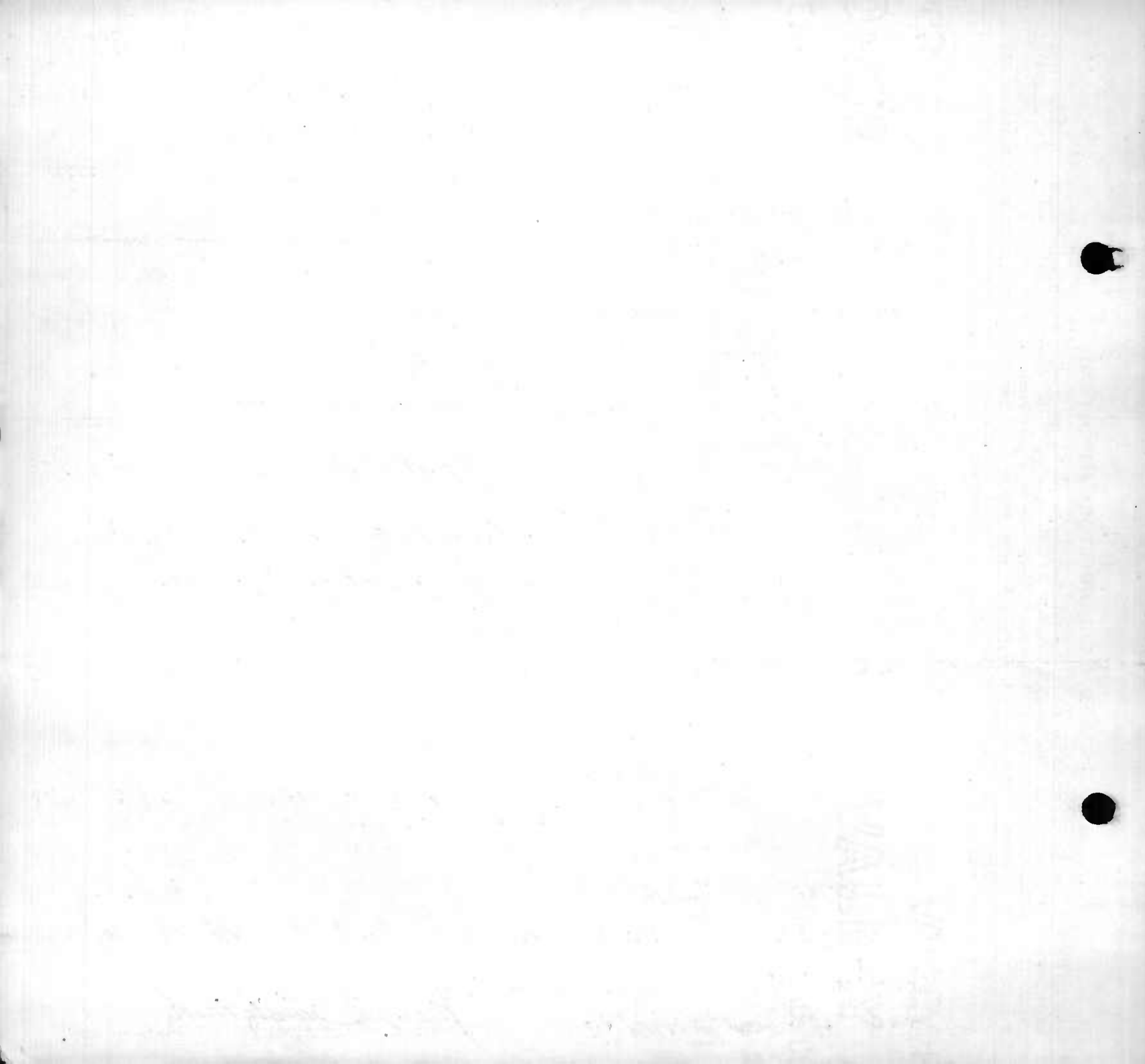
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

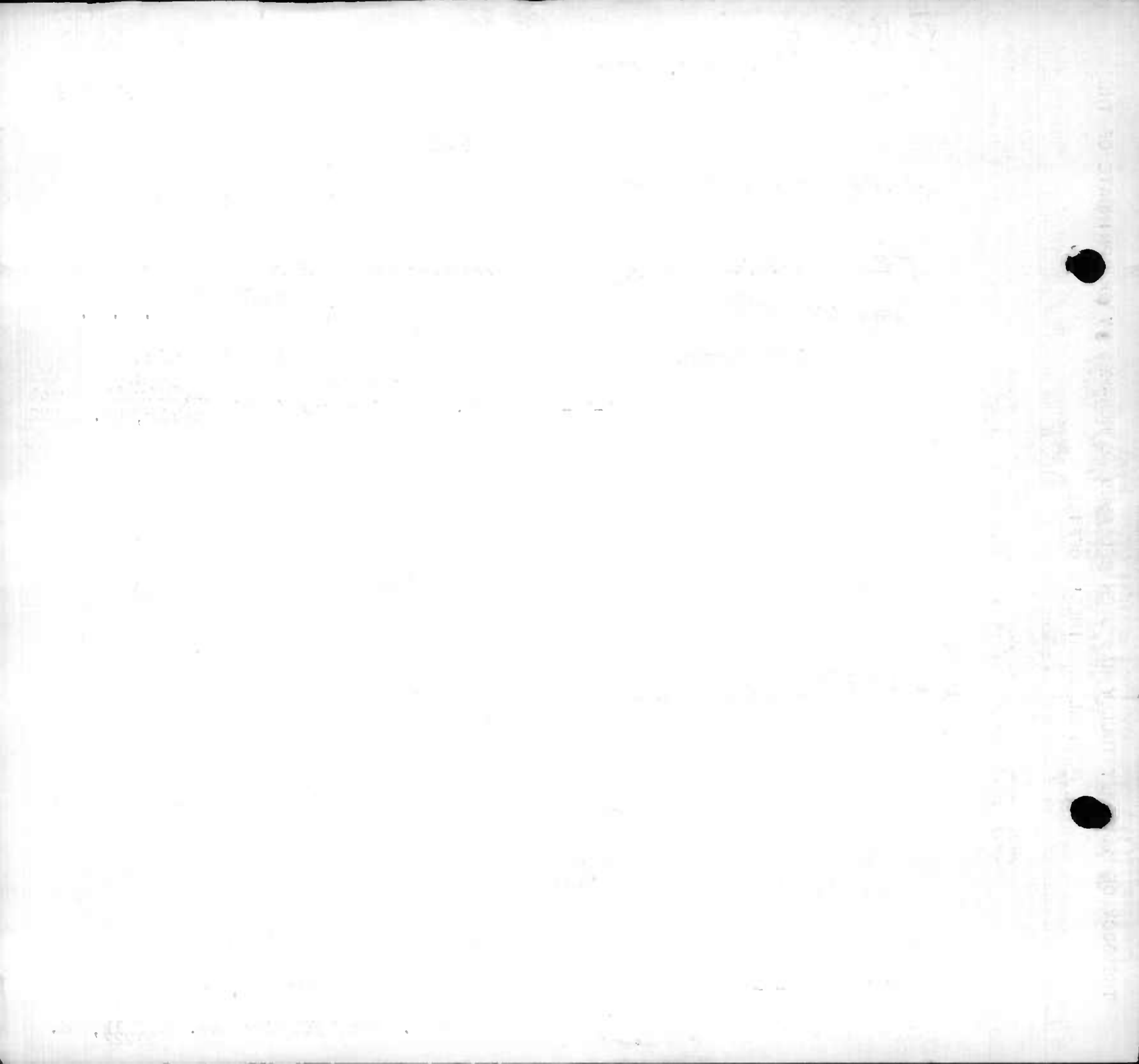
A-536 70 5857		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5857	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ANDERSON, Gustav</b>			
2. DATE AND HOUR OF DEATH <b>June 6, 1970 9:30 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Bolton Hill Nursing &amp; Convalescent Ctr.</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		5. CITY OR TOWN <b>Baltimore</b>		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. STREET AND NUMBER <b>316 Oberle Avenue</b>	
8. FULL NAME OF HOSPITAL OR INSTITUTION <b>90</b>		9. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
12. SEX <b>M</b>		13. RACE <b>White</b>		14. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		15. DATE OF BIRTH <b>3-14-88</b>	
16. AGE (In years last birthday) <b>82</b>		17. If Under 1 Yr. Months: Days: Hours: Min.		18. If Under 24 Hrs. Hours: Min.		19. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
20. FATHER'S NAME <b>Unknown</b>				21. MOTHER'S MAIDEN NAME <b>Unknown</b>			
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		23. SOCIAL SECURITY NO. <b>214-05-3333</b>		24. INFORMANT <b>Anna Anderson</b>		25. ADDRESS <b>Same</b>	
26. CAUSE OF DEATH 18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>6/3</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <b>(A) IMMEDIATE CAUSE</b> <i>Cerebral Thrombosis</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <i>arteriosclerotic heart disease</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <i>years</i> <b>(C)</b> <i>benign prostatic hypertrophy</i> <i>years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5/24/70</b>							
22. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> 19 <b>70</b> to <b>6/6</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>6/6</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>ae M...</i>				23B. DATE SIGNED <b>6/8/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT MD</b>	
23D. ADDRESS <b>2 E Rand St Balt Md 21202</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6/9/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Green Mount Crematory</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		25D. ADDRESS <b>1407 Eastern Ave.</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

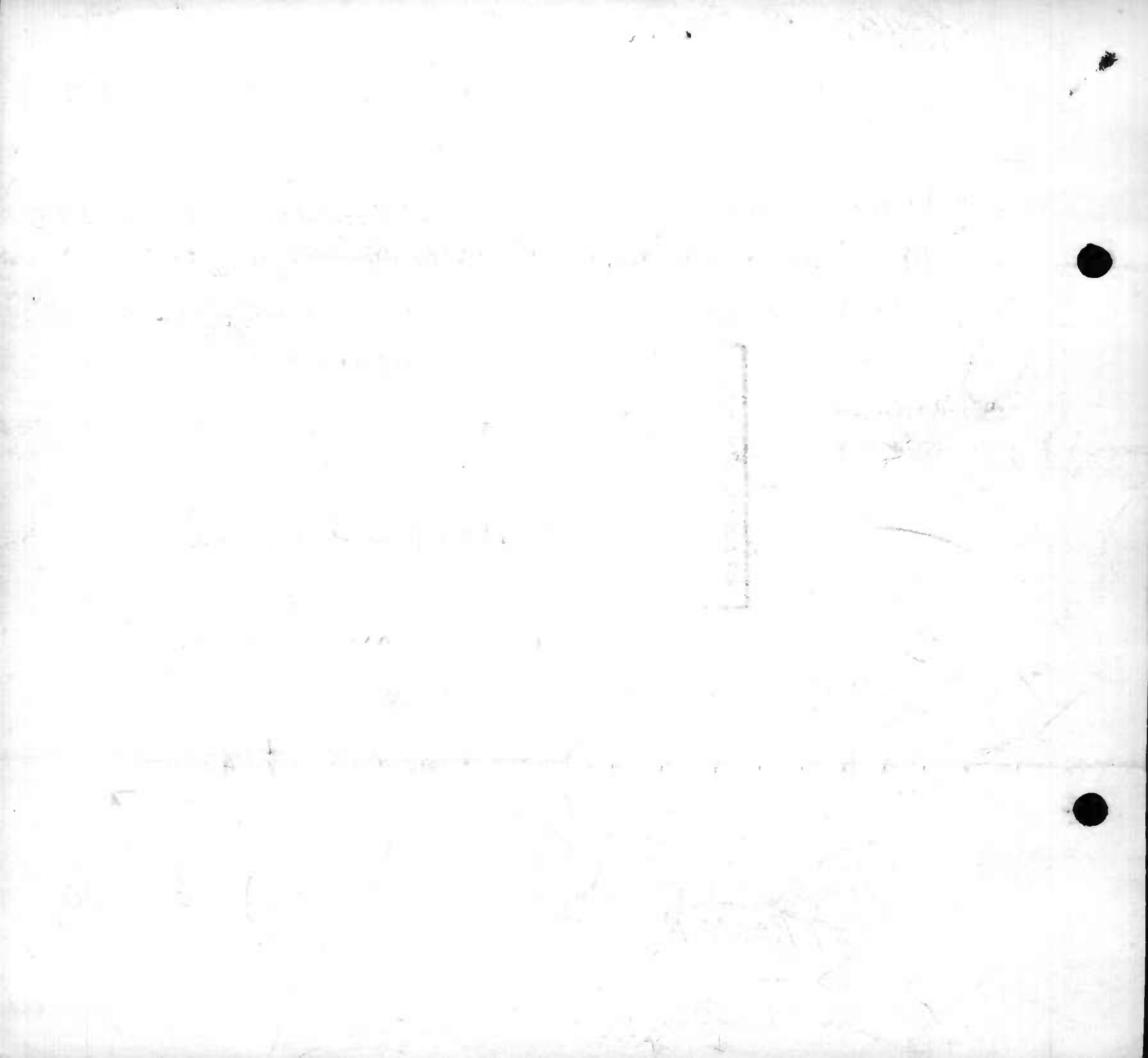
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 5858	
T-400 70 5858		CERTIFICATE OF DEATH			
BIRTH NO. 70 5858		1. NAME OF DECEASED (Type or Print) Margaret M. Tolley			
2. DATE AND HOUR OF DEATH 6-5-70 1:00 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSP. 33		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore 5300			
5. SEX Fe		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-02-16		9. AGE On years lost birthday 53		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Yugoslavia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Simon Ferrara		14. MOTHER'S MAIDEN NAME Margaret Rereich	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 131-18-4575		17. INFORMANT (Daughter) Mrs. Josephine Brzezinski 218 Detroit Street Dundalk, Md. 21222	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Inoperative hemorrhage			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Mitral valve replacement 2°			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C) Rheumatic heart disease		49 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6-5-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral valve disease		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-3-70 19 70 to 6-5-19 70 that (I) (we) last saw the deceased alive on 6-5-19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio Gonzalez R. M.D.				23B. DATE SIGNED 6-5-70	
23C. PHYSICIAN'S NAME (Type) Antonio Gonzalez R. M.D.				23D. ADDRESS Johns Hopkins Hospital Dundalk	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 9 1970		24F. NAME OF REGISTRAR Robert E. Tolley M.D.	
24G. FUNERAL DIRECTOR John J. Duda		24H. ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>K-420</u>		70 5859		
1. NAME OF DECEASED (Type or Print) <u>Kolasky, Joseph David</u>		2. DATE AND HOUR OF DEATH <u>6/5/70</u> <u>1 PM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Univ. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1902</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Univ. Hosp.</u>		C. CITY OR TOWN <u>Balt</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>1309 Hollins St. 21223</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/06</u>	9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Welder</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank Kolasky</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Kalasky</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>215-12-4862</u>		17. INFORMANT <u>Louis Ely</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE DISEASES OR CONDITIONS, if any, giving rise to the above cause as a complicating or underlying condition last <u>Multiple Myeloma</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple Myeloma</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypoglycemia Idiopathic</u>				
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hip Fr</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/5/70</u> to <u>6/5/70</u> that (I) (we) last saw the deceased alive on <u>6/5/70</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael C. Troner</u>				23B. DATE SIGNED <u>6/5/70</u>
23C. PHYSICIAN'S NAME (Type) <u>TRONER</u>		23D. ADDRESS <u>Univ. Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-8-1970</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Ph Cem</u>	24D. LOCATION (City, town, or county) (State) <u>Elkridge, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kepny, Inc</u>
				ADDRESS <u>1600 Balto Md</u>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 5860	
H-435 BIRTH NO. 70-09134 5860		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY HOLTMAN</b>		2. DATE AND HOUR OF DEATH <b>June 5, 1970 10:15 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS Hosp.</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>Md</b> B. COUNTY	
C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>34 2229 1/2 W Platt St</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 30, 1970</b>	9. AGE (In years last birthday) <b>6</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>6 days</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Linda Darlene Fox</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records</b>	
18. <b>531.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Peritonitis</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated Stomach</b>		<b>day</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Premature (1100 gm)</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 31</b> 1970 to <b>June 5</b> 1970 that (I) (we) last saw the deceased alive on <b>June 5</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Josephine G. Brunidos, M.D.</b>		23B. DATE SIGNED <b>June 5, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Josephine G. Brunidos, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Revered</b>		24B. DATE <b>6/8/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St Peter Cem</b>	
24D. LOCATION <b>Balto Md</b>		24E. NAME OF REGISTRAR <b>Thomas J. Keary, Jr.</b>		24F. FUNERAL DIRECTOR <b>1600 Hollins</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Thomas J. Keary, Jr.</b>		25C. FUNERAL DIRECTOR <b>1600 Hollins</b>	

8/10/70 - ulceration & perforation  
Letter from Bow Sec. Hosp  
in file - Bur. of Burstat - Am. Bldg  
ge.

E-552

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH70 5861  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)George  
ALBERT EMINIZER2. DATE OF DEATH  
Known ☐ Month Day Year Hour  
Estimated ☐ 6 5 70 9:38 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Balto. Gen. Hospital D.O.A.

3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
June 5, 1970 9:38 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

July 27, 1902

10. AGE (In years lost birthday)

67

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

4101 Highland Ave. 21225

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Ira Nathan Eminizer

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tug Boat Captain

15. KIND OF BUSINESS OR INDUSTRY

Baker  
Whiteley Towing Co.

15. MOTHER'S MAIDEN NAME

Mazie Thomas

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

Mr. Albert E. Eminizer 4101 Highland Ave. 21225

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)CAUSE OF DEATH  
Ruptured aortic aneurysm, recent

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:(B) arteriosclerotic cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/10/70

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county) (State)

Ritchie Highway A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

McCarthy, F.H.

ADDRESS

237 Patapsco Ave. 21225

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# FUNERAL DIRECTOR: IMPORTANT

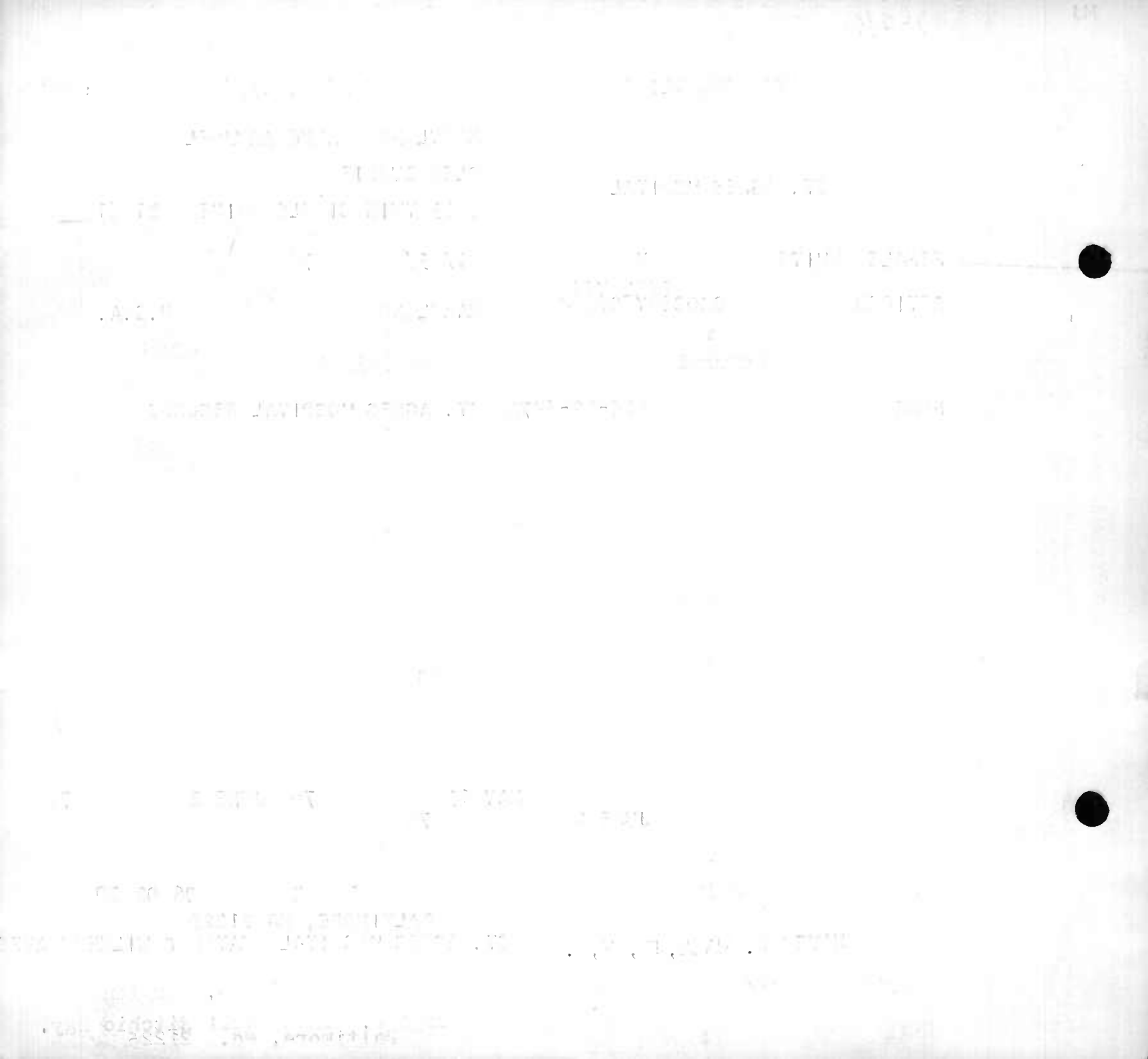
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-362 70 5862		BALTIMORE CITY HEALTH DEPARTMENT		70 5862	
BIRTH NO.		NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MATILDA DIETRICH		6/6/70 10:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD. B. COUNTY B 602	
5. SEX F		6. RACE W		C. CITY OR TOWN BALTIMORE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-92		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 16 N. KENWOOD AVE.	
HOUSEWIFE				11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME JOHN WOLF		14. MOTHER'S MAIDEN NAME MARY KURTZ		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 911 18 6764		17. INFORMANT ADDRESS Virginia Johnson 120 N. Port St.	
no					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.414230.9		Ventricular fibrillation			
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) ASCVD, CHF Diabetes Mellitus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 24 1970 to June 6 1970 that (I) (we) last saw the deceased alive on 6-6 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Z. Vergara, M.D.				23B. DATE SIGNED June 6, 1970	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.				23D. ADDRESS Church Home & Hosp. Balt. Md. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/9/70		Baltimore Cemetery	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Baltimore		Baltimore		Maryland	
25A. DATE REC'D-BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5863</u>	
W-216 70 5863		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		JUNE 2, 1970 2:29P M.	
WASHBURN, ALICE N			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 ST. AGNES HOSPITAL		MARYLAND ANNE ARUNDEL 52-00	
		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
		GLEN BURNIE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER F. RIDGE	
		8913 TWIN CIRCLE DRIVE 21061	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	01/03/00
			9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
RETIRED		EMPLOYEE GROCERY STORE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry McCurtin		Anna Stinot	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NONE		216-12-6573	
17. INFORMANT		ADDRESS	
ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		Ca of lung with metastases	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from MAY 13 19 70 to JUNE 2 19 70 that (I) (we) last saw the deceased alive on JUNE 2 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Haven N. Wall Jr. M.D.		06 02 70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
HAVEN N. WALL JR. M.D.		BALTIMORE, MD 21229	
		ST. AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/5/70	Holy Cross	Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JUN 9 1970	Robert E. Bailey, Jr.	George J. Gonce	4001 Ritchie Hwy. Baltimore, Md. 21225





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5864
CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>D-540</u>		70 5864		
1. NAME OF DECEASED (Type or Print) <u>CATHERINE L. DONNELLY</u>		2. DATE AND HOUR OF DEATH <u>6-8-70</u> <u>2:05 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2102</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>49 NORTH CHARLES GEN. HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Southern Industrial</u>		8. DATE OF BIRTH <u>02-05-94</u> 9. AGE (in years last birthday) <u>76</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Tucker</u>		11. BIRTHPLACE (State or foreign country) <u>Bucks, Ind.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Catherine Inell - 1312 Oak - Glenburne, Ind.</u>
18. <u>569.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>GENERALIZED PERITONITIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>48-72 hrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>PERFORATED SMALL BOWELS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>RENAL FAILURE</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>THE CONGESTIVE HEART FAILURE</u>		
19A. DATE OF OPERATION <u>6-3-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ACUTE ABDOMEN</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> 19 <u>70</u> to <u>6-8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-8</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Jose G. Ortiz M.D.</u>		23B. DATE SIGNED <u>6-8-70</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSE G. ORTIZ M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/11/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ludow Park Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>John J. Covino</u>

Reinhardt

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F-424 70 5865 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO. 70 5865

1. NAME OF DECEASED (Type or Print) <b>RUTH FLEAGLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1827 Calvert St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 7 1970 8:34 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>12/16/1892</b>		10. AGE (In years lost birthday) <b>77</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Grocery</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219-10-2977A</b>	
18. INFORMANT <b>Robert N. Fleagle</b>		15. MOTHER'S MAIDEN NAME <b>Mary Anna Moul</b>	
19. CAUSE OF DEATH <b>011.9 I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2/12/10</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Pulmonary tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6-8-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6/10/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert S. Fisher</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan &amp; Sons Inc.</b>		ADDRESS <b>991 Hollins St. 23 Md.</b>	

VS 151-REV. 1/1/68

100

MEDICAL EXAMINATION CERTIFICATE OF DEATH

THE STATE OF NEW YORK

100

DEATH CERTIFICATE

NAME

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE

DATE OF EXAMINATION

SIGNATURE

DATE OF SIGNATURE

WITNESSES

DATE OF WITNESSES

NOTARY

DATE OF NOTARY

FILE

DATE OF FILE

REMARKS

DATE OF REMARKS

DATE

PLACE OF DATE

TIME

DATE OF TIME

LOCATION

DATE OF LOCATION

STATUS

DATE OF STATUS

REASON

DATE OF REASON

NOTE

DATE OF NOTE

FILE

DATE OF FILE

REMARKS

DATE OF REMARKS

DATE

PLACE OF DATE

TIME

DATE OF TIME

LOCATION

DATE OF LOCATION

STATUS

DATE OF STATUS

REASON

DATE OF REASON

NOTE

DATE OF NOTE

FILE

DATE OF FILE

REMARKS

DATE OF REMARKS

DATE

PLACE OF DATE

TIME

DATE OF TIME

LOCATION

DATE OF LOCATION



FILED IN 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 5866		BALTIMORE CITY HEALTH DEPARTMENT		70 5866	
1. NAME OF DECEASED <u>Willis</u> (Type or Print) <u>LEWIS, Willie Green</u>		2. DATE AND HOUR OF DEATH <u>6-5-70</u> <u>1:15</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u> ADDRESS OR LOCATION <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1509</u>			
5. SEX <u>Male</u>		6. RACE <u>Negroid</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-17-89</u>		9. AGE (in years last birthday) <u>80</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Boliston, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Lewis</u>			
14. MOTHER'S MAIDEN NAME <u>Cornelis Hyson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>6-21-18 to 7-24-19</u>			
16. SOCIAL SECURITY NO. <u>578-03-94-111</u>		17. INFORMANT <u>VA Hospital Records</u> ADDRESS <u>Baltimore, Maryland 21218</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia, Probable Aspiration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiovascular Disease</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>4-5 Years</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Atherosclerosis</u>					
21A. DATE OF OPERATION <u>6-4-70</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>6-4-</u> <u>19 70</u> to <u>6-5-</u> <u>19 70</u> that (X) (we) last saw the deceased alive on <u>6-5-</u> <u>19 70</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard A. Baum</u>		23B. DATE SIGNED <u>6-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD A. BAUM</u> MD	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Carver</u>	
24D. LOCATION (City, town, or county) (State) <u>Beltville, Maryland</u>		25. FUNERAL DIRECTOR ADDRESS <u>W. Ernest Jarvis Co. 1432 You Street, N.W.</u>			

Letter from Veterans Adm. Hospital  
7-27-70 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 70 5867		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5867	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GLADYS M. BRISCOE		JUNE 6, 1970 12 40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2126 MCCULLOH STREET			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	02-04-01	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Nurse		A & L Home		AR. CO. MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JAMES HOLMES		ANNIE BURLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-03-3605		FRANCES BAUCKS 2126 MCCULLOH ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 months	
ANTECEDENT CAUSES		(B) PROBABLE DRUG REACTION DUE TO, OR AS A CONSEQUENCE OF:		2 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DIABETES, HYPERTENSION		20 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from MAY 21, 1970 to JUNE 6, 1970 that (I) (we) last saw the deceased alive on JUNE 6, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22A. SIGNATURE				23B. DATE SIGNED	
Richard Bensinger MD				JUNE 6, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RICHARD BENSINGER MD				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/1/70		BALTO NATIONAL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1970		John G. ...		John G. ... 635 N. ...	

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B-346 70

5868

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5868

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH BUTLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6 6 70 2:00 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>June 6, 1970</b> 2:00 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>June 7-1918</b>		10. AGE (In years last birthday) <b>51</b>		E. STREET AND NUMBER <b>Balto. 2803 BAKER ST</b>	
11. BIRTHPLACE (State or foreign country) <b>Brownsville Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PAUL BUTLER</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>PUB. SCHOOL</b>		15. MOTHER'S MAIDEN NAME <b>GERTRUDE TRACY</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		17. SOCIAL SECURITY NO. <b>220-06-9931</b>		18. INFORMANT ADDRESS <b>PAULETTE BUTLER 427 PENROSE</b>	
19. CAUSE OF DEATH <b>E810 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID INJURY OCCUR? <b>2803 Baker St. (Basement)</b>				22F. HOW DID INJURY OCCUR? <b>Subject fell down stairs</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>6 5 70 11:30</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>6/6/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>6/10/70</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDEN PK. NATIONAL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Marshall Phelps</b>		25D. ADDRESS <b>688 N GILMAN ST</b>			

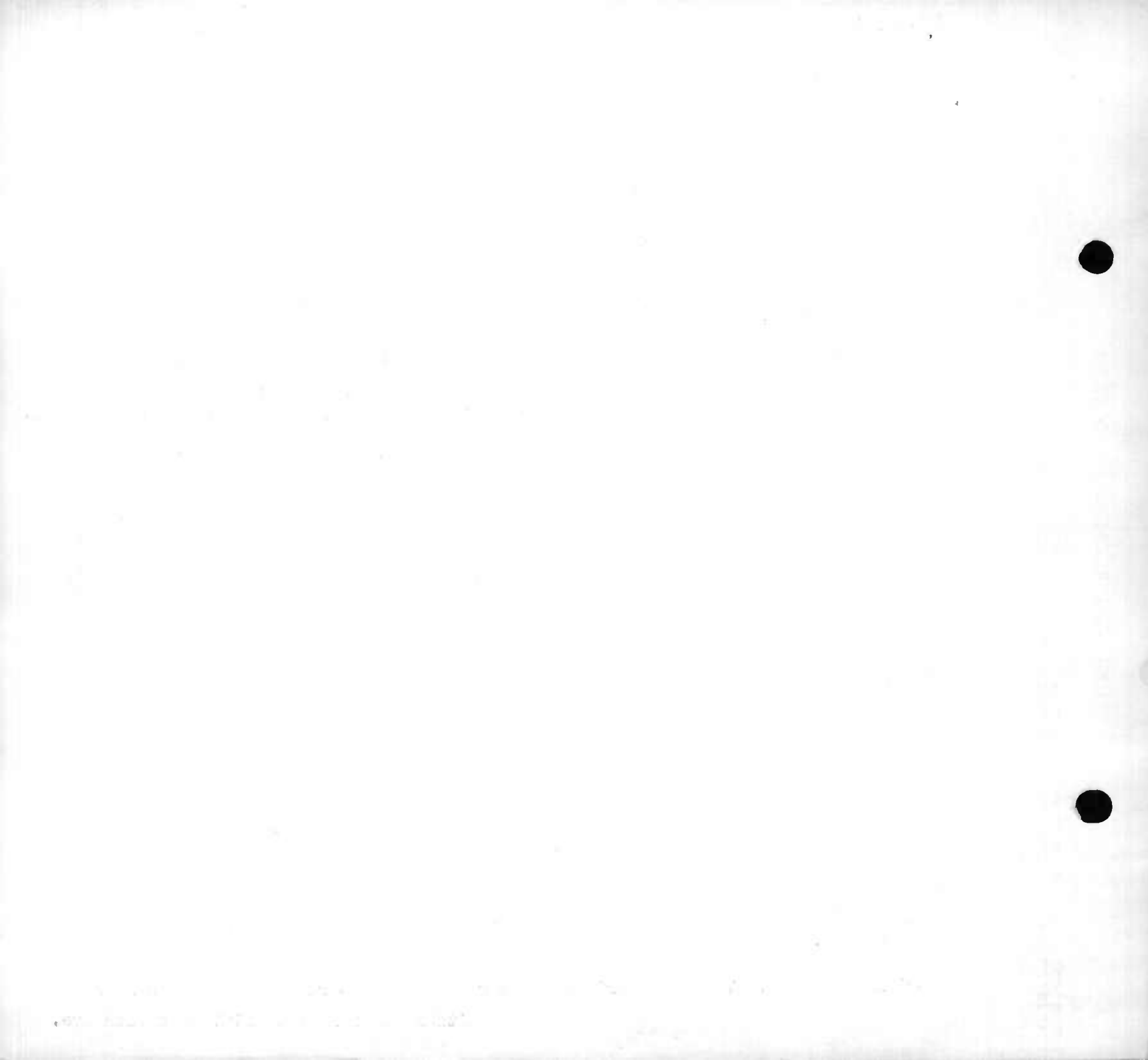
June 7th 1921  
Bismarck, N. D.  
Dear Mr. [illegible]  
Enclosed are 2 copies of the [illegible] [illegible]  
for [illegible] [illegible] [illegible] [illegible]

Very truly yours,  
[illegible]  
[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>6</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5869</u>	
1. NAME OF DECEASED (Type or Print) <u>Jefferson Milton E. Sr.</u>		2. DATE AND HOUR OF DEATH <u>June 7, 1970 1 10<sup>00</sup> a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>Maryland Balto.</u>		B. COUNTY <u>5300</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>5306 Dogwood Road</u>					
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/10</u>	9. AGE (in years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Space Cleaners Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland (Balto.)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Charles Jefferson (late)</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Freshour (late)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>213-09-1658</u>		17. INFORMANT <u>Mrs. Katherine Jefferson, 21207 Dr. F. Cole 5306 Dogwood Rd., Balto., Md.</u>			
18. <u>162-1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Suppurative Bronchitis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Abcess in @ upper lobe, Staph</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>pneumonia</u> (C) <u>Bronchogenic Squamous CA, @</u> <u>Ischemic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days - wk.</u> <u>3 weeks</u> <u>Years</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5-14-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bronchogenic Carcinoma</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from <u>4/30</u> 19 <u>70</u> to <u>6/7</u> 19 <u>70</u> that (I) <u>did</u> last saw the deceased alive on <u>6/7</u> 19 <u>70</u> and that (in my) <u>certified</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Gary W. Miller M.D.</u>		23B. DATE SIGNED <u>6/7/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Gary W. Miller</u>	
23D. ADDRESS <u>827 Linden Ave. Balto.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>6/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.A.</u>		25C. FUNERAL DIRECTOR <u>Witzke Funeral Home 4101 Edmondson Ave. Baltimore, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5870</span>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Lanahan, James A</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>6/6/70</u> <u>found dead in bed</u> <u>at home</u> <u>at</u> <u>7 A.M.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>USPHS Hosp.</u> <u>Baltimore, Md.</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Balt</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5607 Windsor Mill Rd.</u>			
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>Cauc</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8/29/17</u>	<b>9. AGE</b> (In years lost birthday) <u>52</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Capt.</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Ship.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md (Baltimore, Md.)</u>	
<b>13. FATHER'S NAME</b> <u>(Dominick A. Lanahan)</u> <u>James E. Lanahan</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USA</u> <u>42-46</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220-07-8520</u>		<b>17. INFORMANT</b> <u>Mrs. Elaine C. Lanahan, 5607 Windsor Mill Rd.</u> <u>Chart</u> <u>Baltimore, Md. 21207</u>	
<b>CAUSE OF DEATH</b>					
<b>I.</b> <u>410.9</u> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>(A) IMMEDIATE CAUSE</b> <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) ASCVD, severe</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b>		
<b>II.</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>mins</u>  <u>yrs</u>		
<b>MEDICAL CERTIFICATION</b>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>9/12/1966</u> <b>to</b> <u>6/6/1970</u> <b>that (I) (we) last saw the deceased alive on</b> <u>6/1</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Peter J. Philpott MD</u>				<b>23B. DATE SIGNED</b> <u>6/6/70</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Peter J. Philpott MD</u>				<b>23D. ADDRESS</b> <u>USPHS Hosp Balt.</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>6/10/70</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Loudon Park Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore Maryland</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JUN 9 1970</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert F. Witzke</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Witzke Inc. 1630 Edmondson Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-420		70 5871		BALTIMORE CITY HEALTH DEPARTMENT		70 5871	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MARY B. TELLIS</b>				2. DATE AND HOUR OF DEATH <b>6/8/70 8:24 am</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Luthereen Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1511</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3520 N. Hilton Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-79</b>	9. AGE (In years last birthday) <b>90</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Lawrence Limmer</b>			14. MOTHER'S MAIDEN NAME <b>Sabine M. BARTHALOMEW</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>113-0953780</b>		17. INFORMANT <b>Annette Rohleder (daughter)</b>		
			ADDRESS <b>6204 Moyess Ave</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD &amp; chronic brain syndrome</b>			IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Interchaneptic fracture of femur</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>5/25/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>fracture of hip</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>5/15/70 2:00</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pr. fell down while working about</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5/12/70</b> to <b>6/8/70</b> and that (I) (we) last saw the deceased alive on <b>6/8/70 8:24 am</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Pratima Bose M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>6/8/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>PRATIMA BOSE M.D.</b>				23D. ADDRESS <b>Luthereen Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-11-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Howe-Roseman Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>James S. [illegible]</b>		25C. FUNERAL DIRECTOR <b>Diggs Bros Inc 7110 Belair Rd.</b>			

211171.8 KRAM

business

Bill Moore

250 m. Hollow

OF PG-P6-01

A.Z.U. b/m gromituaE

Howsewife AT Home

# RAWRANCE PIMMERS

Answered by  
SVA member

81X-09-2578D

Ascidia (1892) - modernized

Other important features of female

2/10/70

Not present

05/21/20

12/12 18/12 18/12

212 05

05

Partnership

6M 3204 AMITAGG

butcher Hooper

Bureau P-1-50 Home Research Bureau Baltimore Maryland



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

70 5872

BIRTH NO.

70 5872

1. NAME OF DECEASED  
(Type or Print)

STEWART, Lester Slater

2. DATE AND HOUR OF DEATH

6 JUNE 1970 1:45 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

VETERANS ADMINISTRATION HOSPITAL  
3900 LOCH RAVEN BOULEVARD  
BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

BALTIMORE MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2502 GARRISON BOULEVARD

5. SEX

MALE

6. RACE

NEGRO ID

7. MARRIED

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-7-12

9. AGE (in years last birthday)

57

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

JOHNSTOWN, PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM STEWART

14. MOTHER'S MAIDEN NAME

LAURINA WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

10-9-42 TO 12-31-45

16. SOCIAL SECURITY NO.

213-10-7389

17. INFORMANT

VA HOSPITAL RECORDS

ADDRESS

3900 LOCH RAVEN BLVD, BALTO, MD 21218

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:  
① 62 Year of Undetermined Etiology  
② Anemia 2°  
③ Chronic Alcoholism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 3 JUNE 19 70 to 6 JUNE 19 70 that (X) (we) lost saw the deceased alive on 6 JUNE 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

RICHARD A. BAUM

MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/6/70

23D. ADDRESS

3900 LOCH RAVEN BLVD  
BALTIMORE, MD 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/10/70

24C. NAME OF CEMETERY OR CREMATORY

Louden Park National Cem.

24D. LOCATION

Baltimore Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

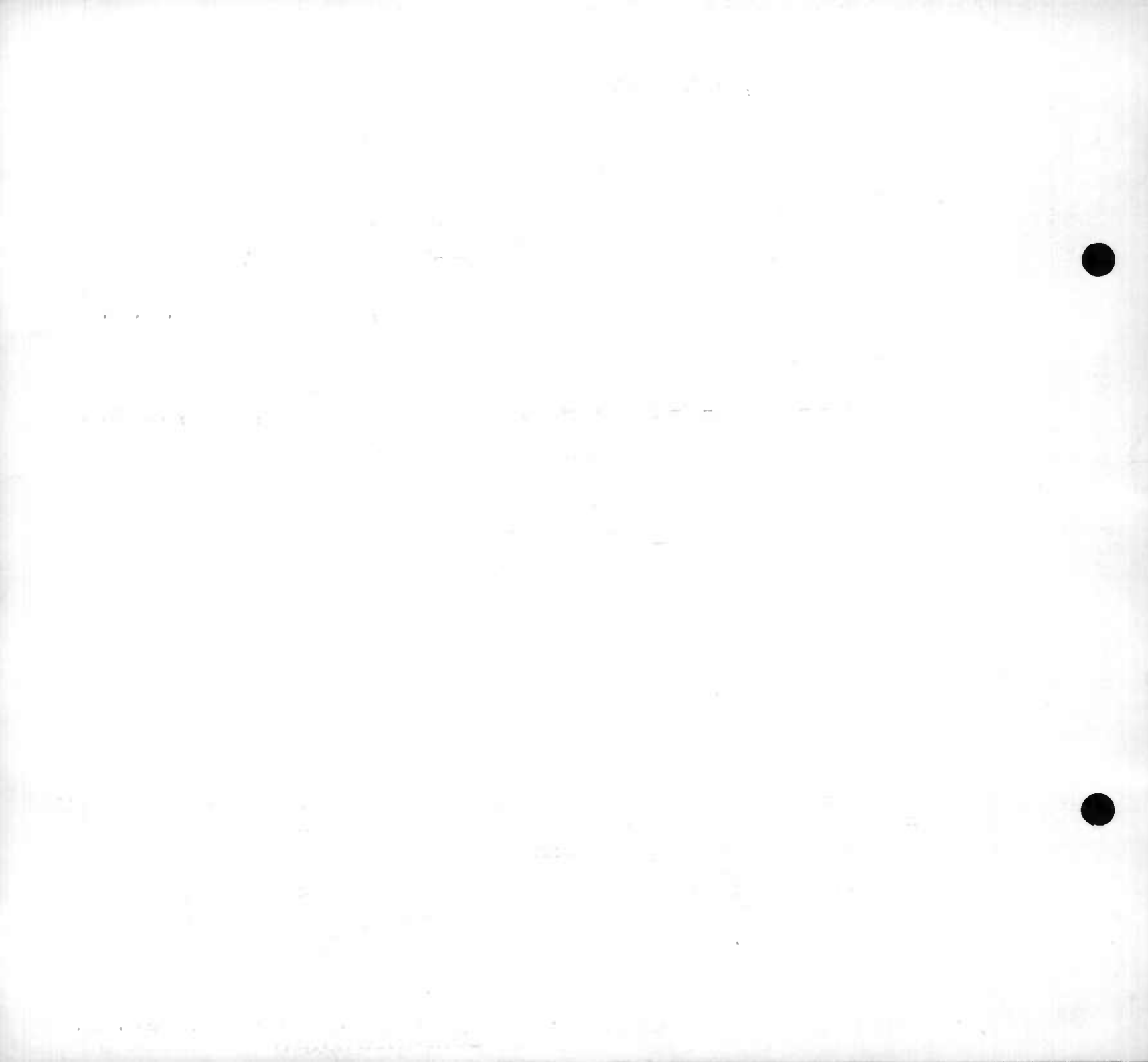
25B. NAME OF REGISTRAR

Robert E. Gaber, M.D.

25C. FUNERAL DIRECTOR

Stetson D. Wilson 1913 W. Balto. St.

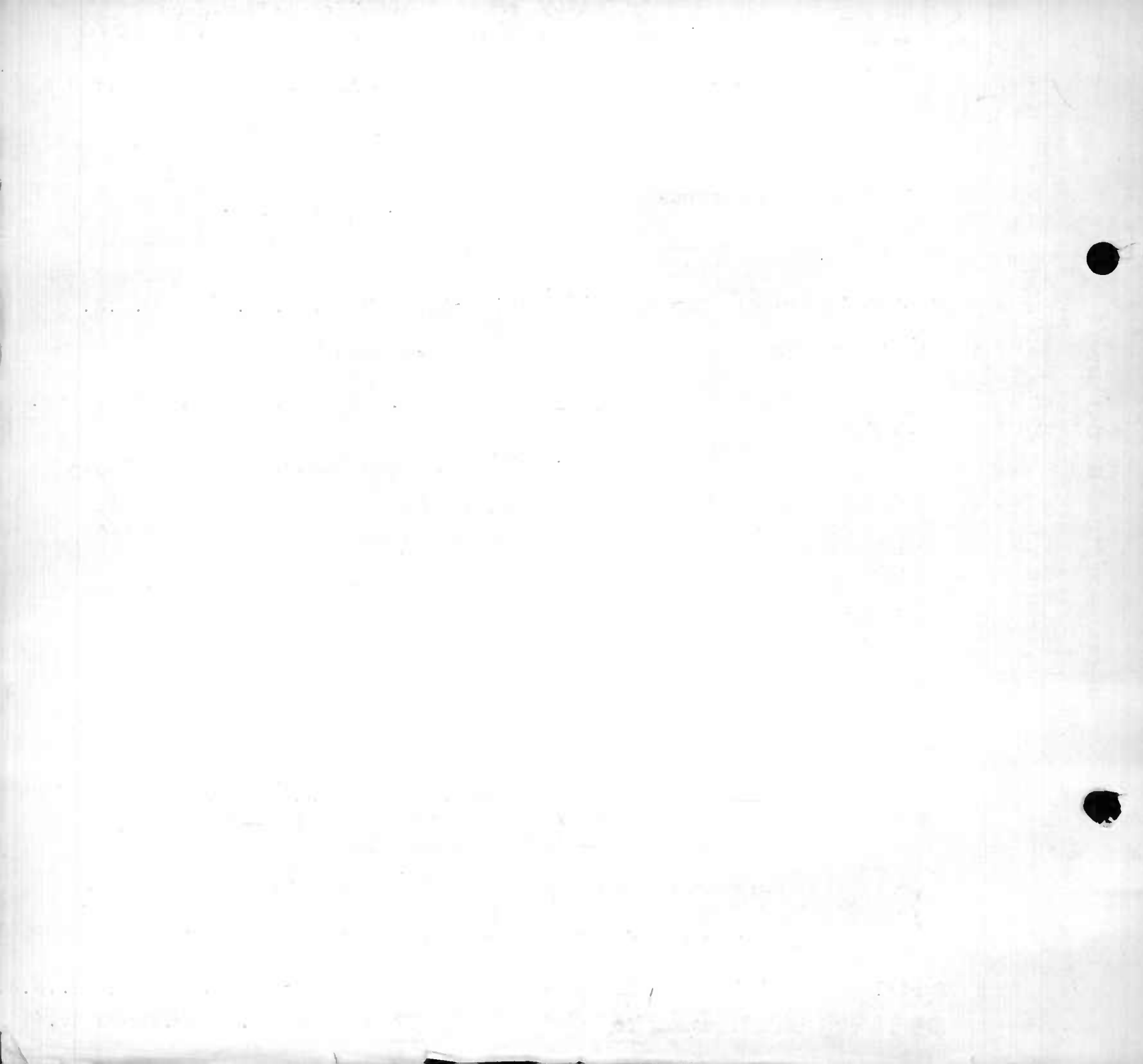
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

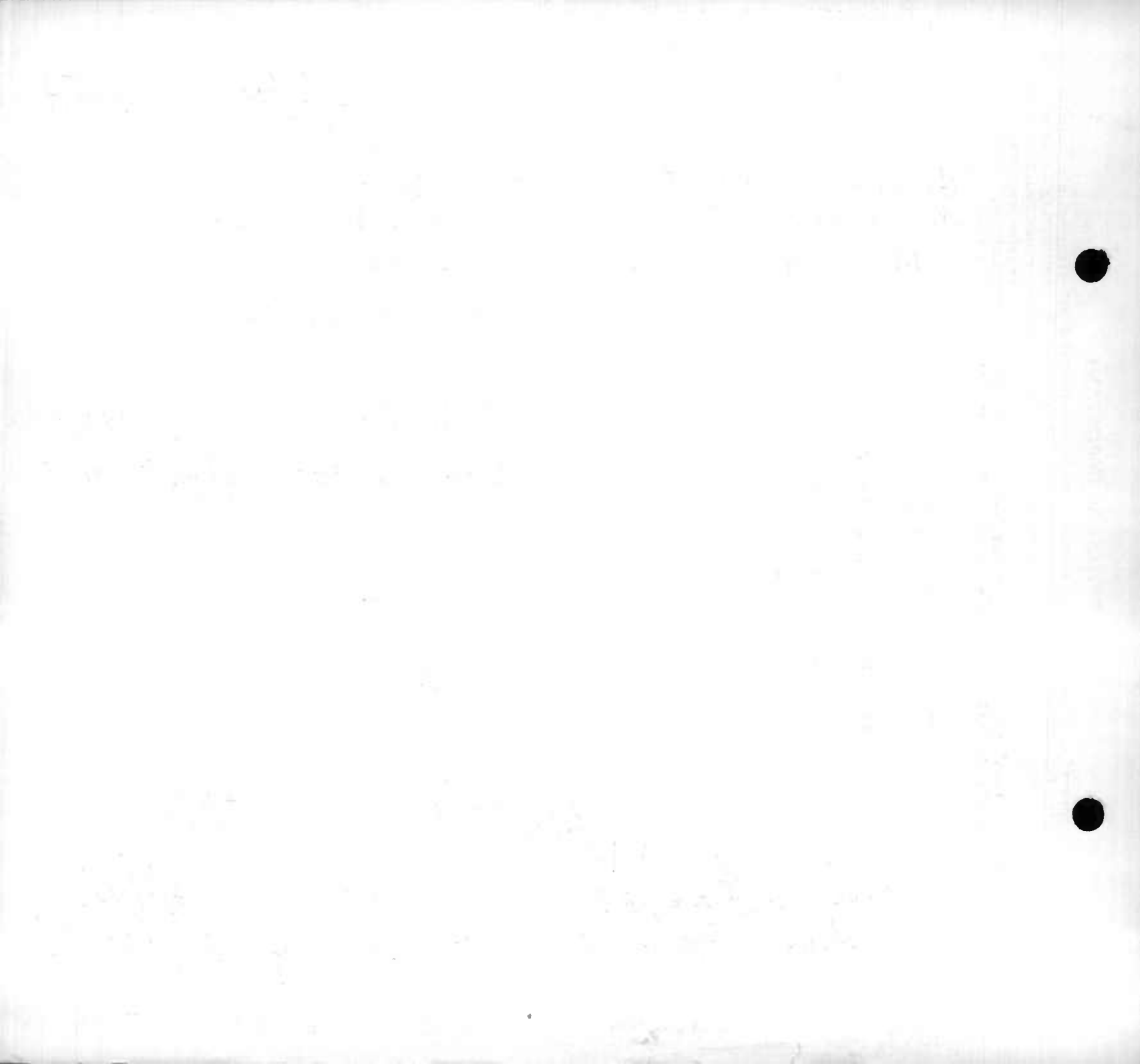
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5873</b>	
S-363 70 5873		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
RUTH MAE STEWART		June 4, 1970		8:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		Maryland			
1900 Maryland Avenue		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1900 Maryland Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/15/1898	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Varied (Retired)		Various (Barmaid)		Phillipsburg, N. J.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
U.S.A.		Louis Vought			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Susan Hess		No			
16. SOCIAL SECURITY NO.		17. INFORMANT Self: ADDRESS			
219-07-4331A		Ruth M. Stewart, 1900 Maryland Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Acute Chronic Respiratory Failure		13 yrs.	
		Cov Pulmonale		Life	
		Bronchiectasis			
19. ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C).....					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NO				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>January 1965</u> to <u>June 4 1970</u> , that (I) (we) last saw the deceased alive on <u>MAY 19 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
B. S. Karpers Jr. M.D.		6-5-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
B. S. KARPERS JR. M.D.		514 MEDICAL ARTS BLDG, BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/8/70		Phillipsburg Cemetery	
				Phillipsburg, Warren Co., N.J.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1970		Robert E. Taylor, Jr.		STEWART & MOWEN CO. 108 W. North Av. (1)	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

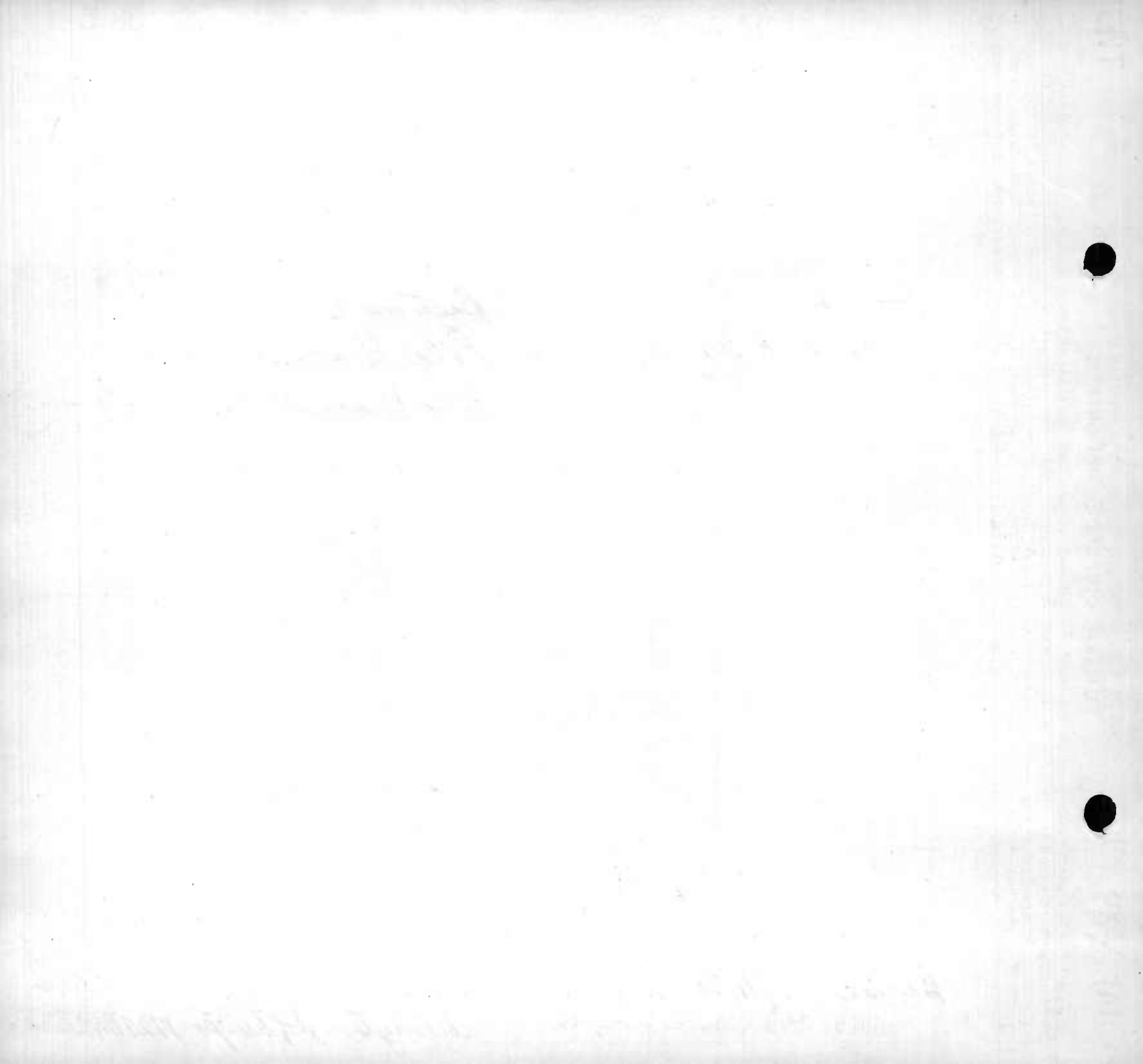
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5874	
BIRTH NO.		W-300 70 5874		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		White, Madison		2. DATE AND HOUR OF DEATH 6/5/70 9:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION GRANADA - 4017 Liberty Hgts Ave Nursing Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-20-82		9. AGE (In years, months, days, hours, minutes) 7-20-82		10. AGE (In years, months, days, hours, minutes) If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Hopewell, Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Medical Record, 4017 Liberty Hgts Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4369 I CAUSE OF DEATH CVA with Rt. Hemiplegia 3 weeks' ANTICIPATED CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA with Rt. Hemiplegia 3 weeks' (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks'	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/4/70 to 6/5/70 that (I) (we) last saw the deceased alive on 6/4/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE HOLLIS J. JENKINS		23B. DATE SIGNED 6/5/70	
23C. PHYSICIAN'S NAME (Type) HOLLIS J. JENKINS		23D. ADDRESS 1801 Greenway		23E. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/70		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore MD		24E. DATE REC'D BY HEALTH DEPT. JUN 9 1970		24F. NAME OF REGISTRAR Robert E. J. J. J.	
24G. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave		24H. ADDRESS 1206 W North Ave		24I. ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5875</b>
BIRTH NO.		70 5875		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <b>WILLIAMS DELBERT ANDRE</b>		2. DATE AND HOUR OF DEATH <b>6/6 1970 11:55P</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL OF MD. 730 ASHBURTON ST. BALTIMORE.</b>		A. STATE <b>MD. 21225</b> B. COUNTY <b>2532</b>		
		C. CITY OR TOWN <b>BALTIMORE.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>1106 CHERRY HILL ROAD APTK.</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-56</b>	9. AGE (In years last birthday) <b>14</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>Delbert A. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Ella Grace Cooper</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ella Grace Williams</b>
				ADDRESS <b>Same</b>
18. <b>282.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>SICKLE CELL ANEMIA.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HAEMOLYTIC CRISIS.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) _____ (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>6-4</b> 19 <b>70</b> to <b>6-6</b> 19 <b>70</b> , that <b>(I)</b> <del>(we)</del> last saw the deceased alive on <b>6-6</b> 19 <b>70</b> and that in <b>(my)</b> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <del>(We)</del> <b>(did)</b> <del>(did not)</del> view the body after death.				
23A. SIGNATURE <b>Rajinder P. Gandhi</b>		23B. DATE SIGNED <b>6/6/70</b>		23C. PHYSICIAN'S NAME (Type) <b>RASINDER PALGANDHI</b>
		23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE MD. 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6/11/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Carter Mem. Ch. Laurel</b>	24D. LOCATION (City, town, or county) (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Delington S. Pidgeon</b>
				ADDRESS <b>1721 M. Monast</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5876	
BIRTH NO. 70 5876		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HAZEL A. HART</b>		2. DATE AND HOUR OF DEATH <b>6/4/70 6:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Sinor Hotel, Balto</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1537</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinor Hotel, Balto</b>		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>C</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/30/22</b>		9. AGE (In years last birthday) <b>48</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Frank Winston</b>		14. MOTHER'S MAIDEN NAME <b>Frank Galdie Harper</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William P. Hart</b> ADDRESS <b>Same</b>	
18. <b>IX</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pneumonia</b> 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic disease</b> <b>Carcinoma Breast</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>6/1/70</b> 19 to <b>6/4/70</b> 19 that (H) (we) last saw the deceased alive on <b>6/4/70</b> 19 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. M. Venn</b>		23B. DATE SIGNED <b>6/4/70</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/9/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
24D. LOCATION <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>William P. Hart</b>		25D. ADDRESS <b>1727 N. Mount St.</b>			



70 5877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5877

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JEFFERSON MILTON E.

2. DATE  
OF DEATHKnown ☐ Month Day Year Hour  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)

1709 Bentalou Street

3. DATE  
PRONOUNCED DEADMonth Day Year Hour  
June 3, 1970 12:22 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1503

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

8/17/96

10. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1709 N. Bentalou Street

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James R. Jefferson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Lee Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

216-07-0765

18. INFORMANT

James L. Jefferson

ADDRESS

825 Harrison  
Baltimore, Md.

19. 4/24

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/4/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/8/70

24C. NAME OF CEMETERY or CREMATORY

Carmen Memorial

24D. LOCATION (City, town, or county)

Laurel

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1970

25B. NAME OF REGISTRAR

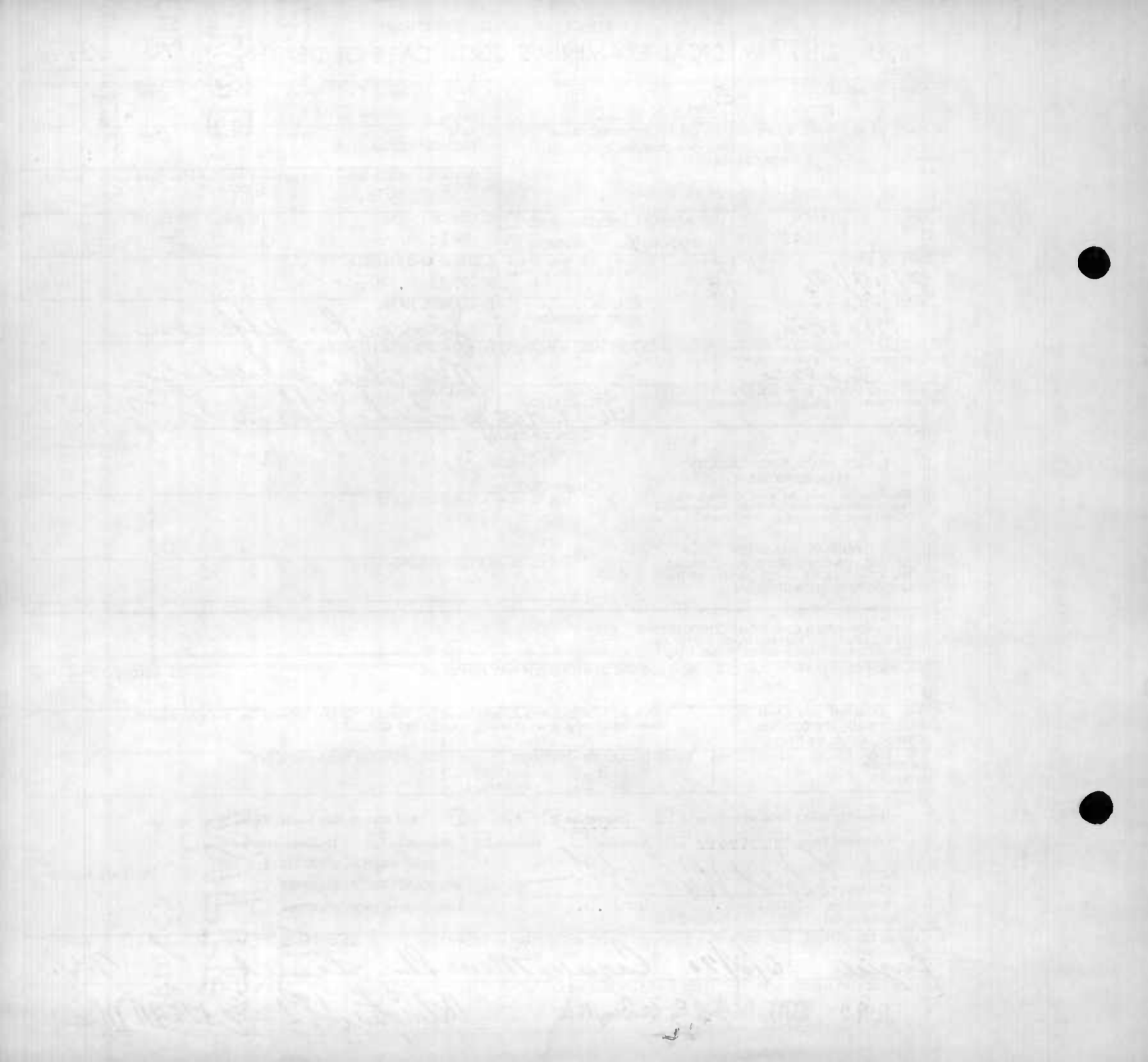
Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Wilmington H. Phillips

ADDRESS

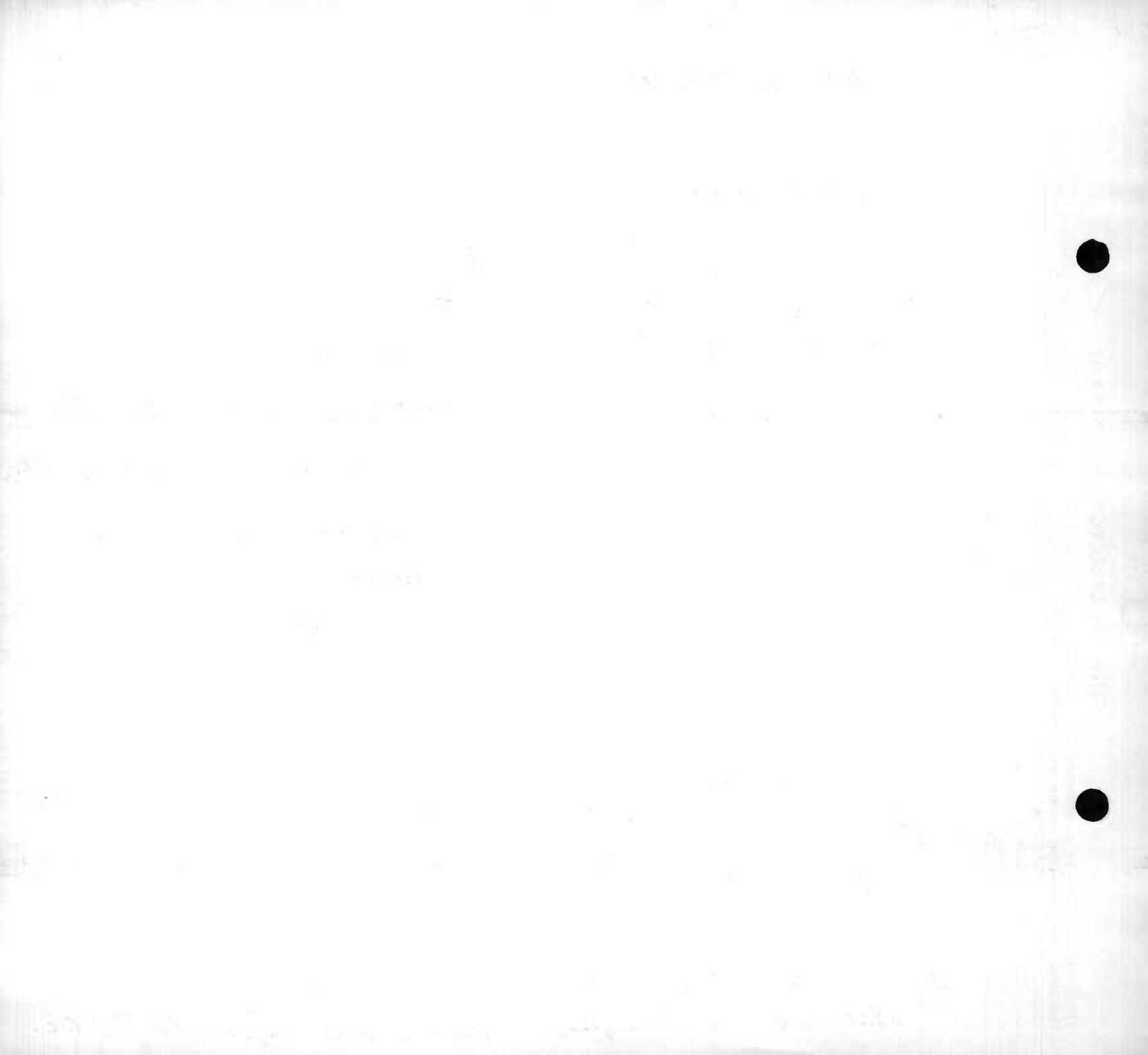
1727 N. Monmouth St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

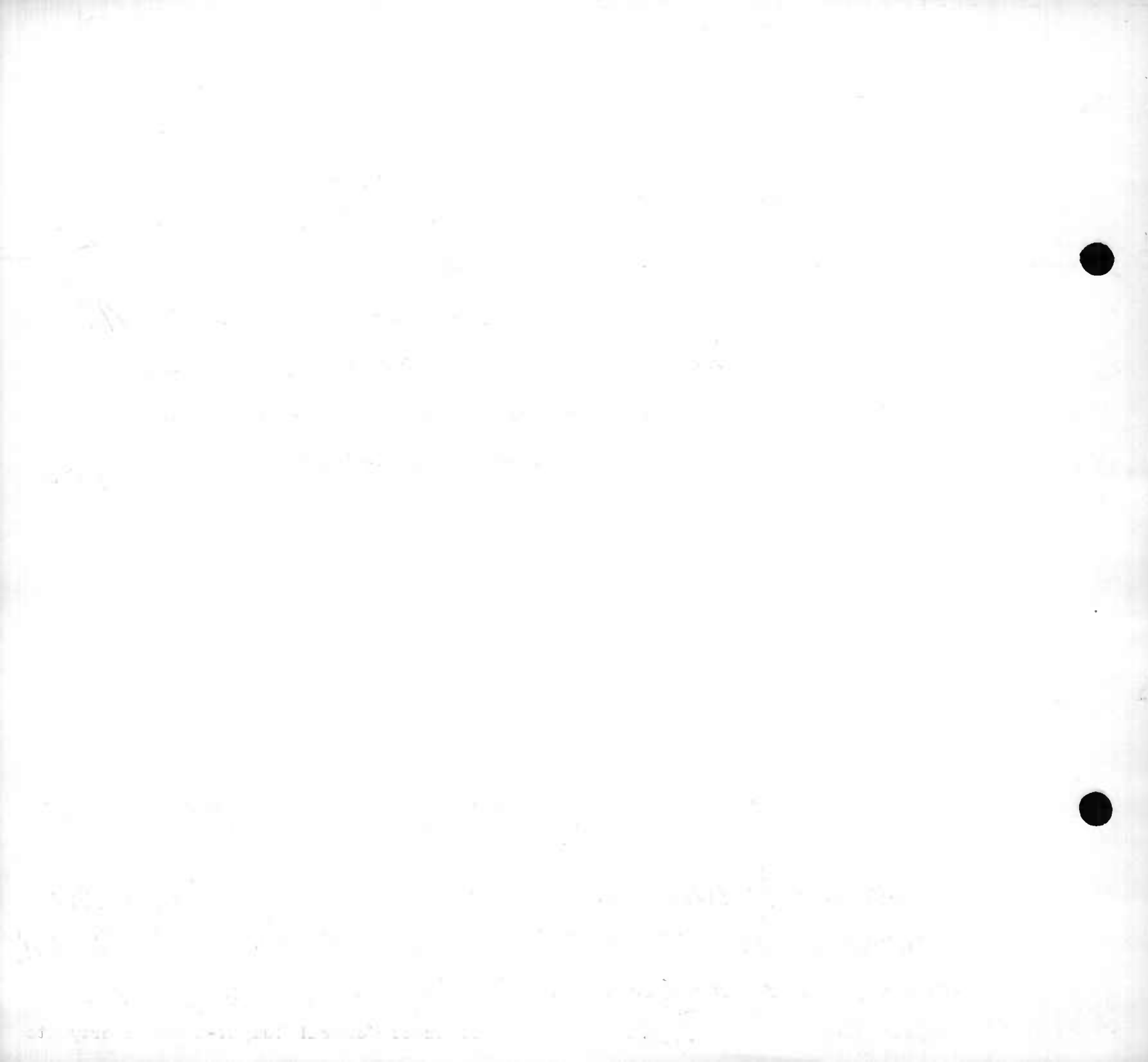
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5878</b>
BIRTH NO. <b>70 5878</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>GUS A. TRIANTOS</b>		2. DATE AND HOUR OF DEATH <b>6/5/70</b> <b>7 26 A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2775</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL</b>		C. CITY OR TOWN <b>BALTIMORE 9</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>1500 W. COLD SPRING LANE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/01</b>	9. AGE (In years last birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT UGR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>ANDREW C. TRIANTOS</b>		
14. MOTHER'S MAIDEN NAME <b>DIAMOND.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS MARIE W. TRIANTOS</b> ADDRESS <b>1500 W COLD SPRING LANE</b>		
18. <b>410.9 4-230.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION 5 days</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIO SCLEROTIC CARDIOVASCULAR</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DIABETES MELLITUS.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>DISEASE</b>		
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIABETES MELLITUS.</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) <b>(this hospital)</b> attended the deceased from <b>6/1</b> 19 <b>70</b> to <b>6/5</b> 19 <b>70</b> that <b>(1)</b> (we) last saw the deceased alive on <b>6/5</b> 19 <b>70</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(1)</b> (We) <b>(did)</b> (did not) view the body after death.				
23A. SIGNATURE <b>Anne L. Liddy</b>				23B. DATE SIGNED <b>6/5/70.</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-8-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Green.</b>
24D. LOCATION (City, town, or county) (State) <b>Wendover Mill Rd.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Paul Schumacher</b> ADDRESS <b>3615 Chestnut Ave.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 5879</b>
BIRTH NO. <b>P.626</b>		70 5879		
1. NAME OF DECEASED (Type or Print) <b>Alice T. Parker</b>		2. DATE AND HOUR OF DEATH <b>June 6-1970</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>004211 Liberty Hgts Ave</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7-31-1905</b>		9. AGE (In years last birthday) <b>64</b>		10. Under 1 Yr. 11. Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norfolk-Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>W Jones</b>		
14. MOTHER'S MAIDEN NAME <b>Alice Stallings</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>218-01-0741</b>		17. INFORMANT <b>Helen Clark-Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <b>Bronchogenic cancer</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>June 6, 1970</b> that (I) <del>was</del> lost saw the deceased alive on <b>May 11, 1970</b> and that (in my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.				
23A. SIGNATURE <b>Marvin Goldstein, M.D.</b>		23B. DATE SIGNED <b>June 6, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN M.D.</b>
23D. ADDRESS <b>6001 Park Heights Ave. - Balto., Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>6-9-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D. BY HEALTH DEPT. <b>JUN 8 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Armacost Funeral Chapel-4600 Liberty Hts</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-252 70 5880		BALTIMORE CITY HEALTH DEPARTMENT		X	REG. NO. 70 5880
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Washington, Jeremiah</b>			2. DATE AND HOUR OF DEATH <b>6/1/70</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Good Samaritan Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Shadyside, Md.- Anne Arundel Cty.</b> C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5200</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-1911</b>	9. AGE (In years lost birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pr. Geo. Co. Md.</b>	
13. FATHER'S NAME <b>Joseph C. Washington</b>			14. MOTHER'S MAIDEN NAME <b>Pearl Dent</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank Washington</b> ADDRESS <b>Rt. 2 - Box 139 E Brandywine, Md.</b>	
18. <b>199.0 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS.</b>		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC CARCINOMA (PRIMARY SITE-UNCLEAR)</b>					
(B) <b>H/O ALCOHOLISM</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>H/O MULT. ABD. SURGERY</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>INTRACTABLE DIARRHEA 20° TO ABOVE</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/28/70</b> 19 to <b>6/1/70</b> 19, that (I) (we) lost saw the deceased alive on <b>6/1/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jerome L. Rubin</b>				23B. DATE SIGNED <b>6/1/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JEROME L. RUBIN, M.D.</b>				23D. ADDRESS <b>JOHN H. ODORINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 5/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Mary Church Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Piscataway - Pr. Geo. Co. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Marshall Adams Aquasco, Md.</b>	

104

RECEIVED  
(10/10/10)

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10

10/10/10

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10/10/10

James R. Smith

10/10/10

10/10/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

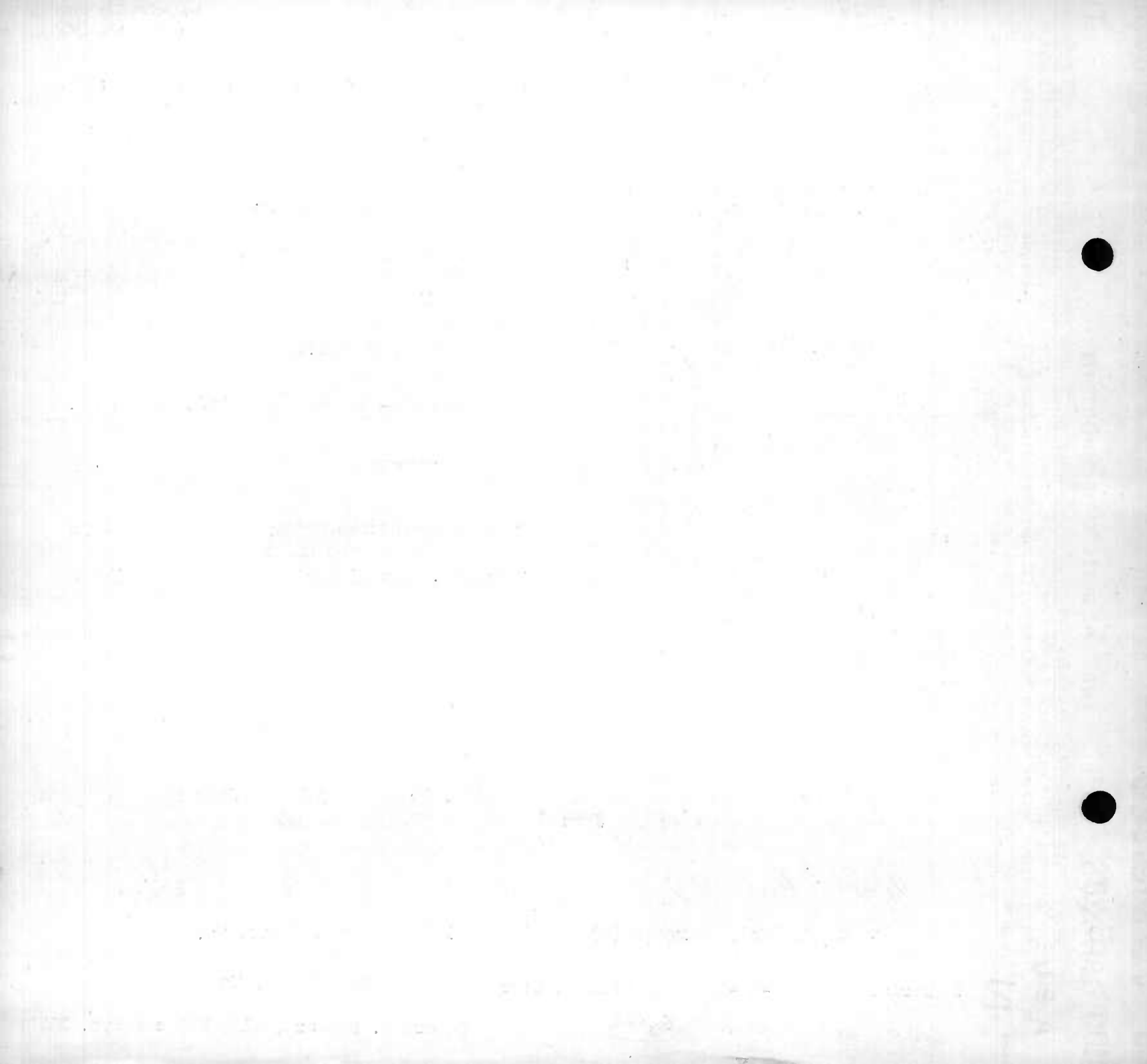
P-326 70 5881				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5881	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Robert Carl Pettigrew</i>				2. DATE AND HOUR OF DEATH <i>6/6/70 7:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1701</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. of Maryland Hosp.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>E. Baltimore St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/27/06</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Rest.</i>		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Frank Pettigrew</i>				14. MOTHER'S MAIDEN NAME <i>Lucy Stewart</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>226-09-4810</i>		17. INFORMANT ADDRESS <i>Citty Funeral Home Reidsville, N.C.</i>	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>162.1 I Carcinoma of the lung</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: wide spread metastasis</i>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/27/70</i> 19__ to <i>6/6/70</i> 19__ that (I) (we) lost saw the deceased alive on <i>6/6/70</i> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Shafitii</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>E. Shafitii</i>				23D. ADDRESS <i>Univ. of Md. Hosp. Balt. ind.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 9, 70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenview Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Reidsville, N.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Jaber, MD.</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS <i>Hubbard Funeral Home</i>	

Hospital gave address  
as 416 N. Greene St.  
Knows nothing about  
address on front.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

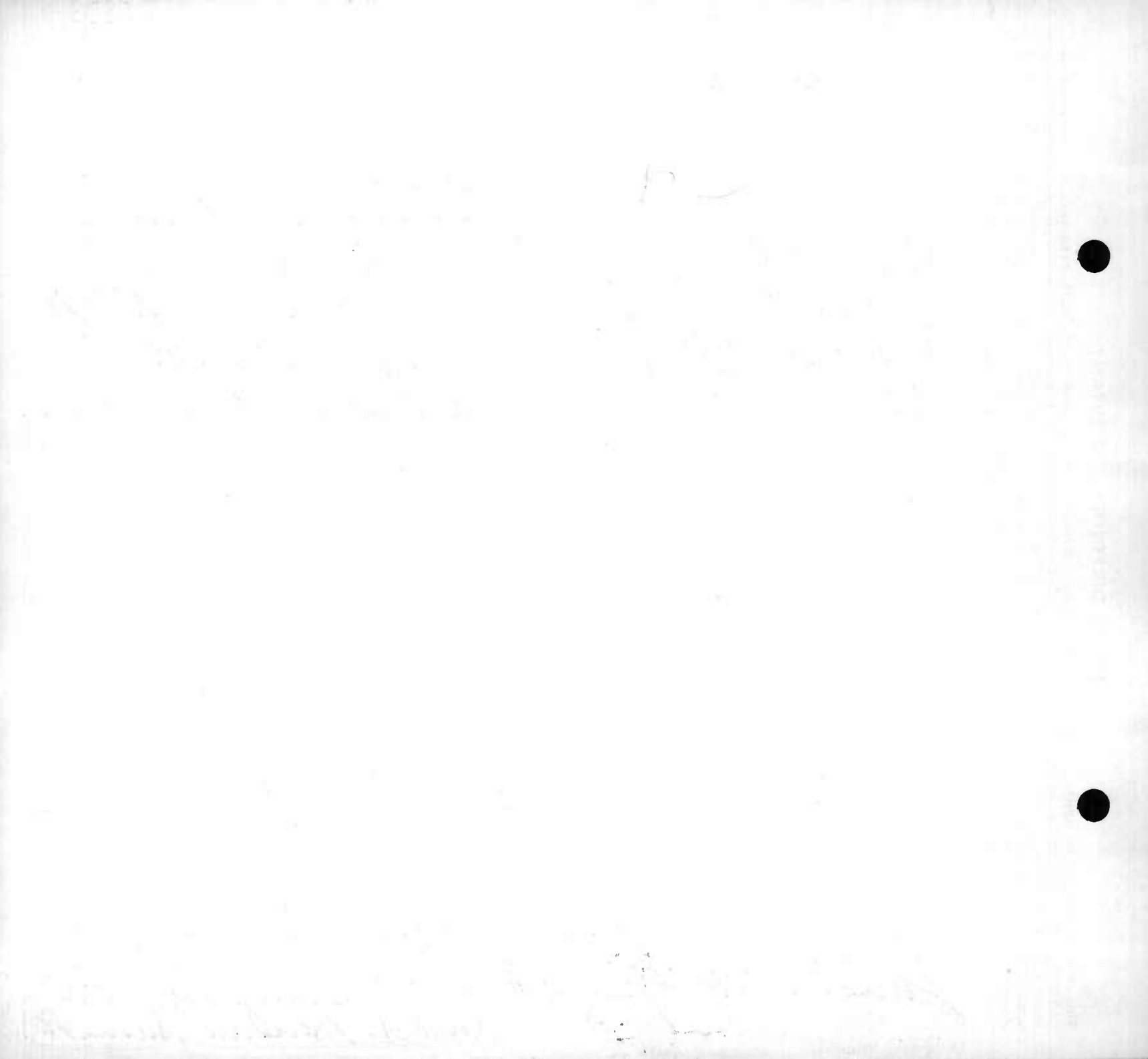
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 5882	
BIRTH NO. 70 5882				1. NAME OF DECEASED (Type or Print) Joyce Mae Bentley		2. DATE AND HOUR OF DEATH June 8, 1970, 1:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		V-40	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway				Texas		C. CITY OR TOWN Dallas	
						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5306 Tremont Street			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/27	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel A. Aly			14. MOTHER'S MAIDEN NAME Vivian Callahan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 444.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Necrosis of bowel		Day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Superior mesenteric artery DUE TO, OR AS A CONSEQUENCE OF: occlusion		Days	
				(C) Atherosclerosis of aorta		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr. 20 1970 to June 8 1970, that (I) (we) last saw the deceased alive on June 8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel P. Ward M.D.				23B. DATE SIGNED 6/8/70			
23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-1970		24C. NAME of CEMETERY or CREMATORY Old Hall Cemetery		24D. LOCATION (City, town, or county) (State) Lewisville, Texas	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160 70 5883		BALTIMORE CITY HEALTH DEPARTMENT		70 5883	
BIRTH NO.		CERTIFICATE OF DEATH		X REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Marshall Shaffer</b>			2. DATE AND HOUR OF DEATH <b>6/5/70 6:15A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>AA</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>704 Riverside Circle</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-11-57</b>	9. AGE (In years last birthday) <b>12</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>J. High</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>	
13. FATHER'S NAME <b>Marshall W. Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Marion Weston</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marshall W. Shaffer - Alone</b> ADDRESS	
18. <b>065X1</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Neural Encephalitis</b>		<b>1 wk</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE PRIMARY DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>YES</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>NO</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR <b>None</b>	
22. I certify that (X) (this hospital) attended the deceased from <b>6-2-70</b> 19 to <b>6-5-70</b> 1970 that (X) (we) last saw the deceased alive on <b>6-5-70</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>6-5-70</b>		23C. PHYSICIAN'S NAME (Type) <b>STAFF, MD</b>	
23D. ADDRESS <b>MERCY HOSP</b>		23E. CITY, TOWN, OR COUNTY <b>Baltimore</b>		23F. STATE <b>MD</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-9-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Springfield Hall</b>	
24D. LOCATION <b>Springfield</b>		24E. CITY, TOWN, OR COUNTY <b>Missouri</b>		24F. STATE <b>Mo</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>[Address]</b>	

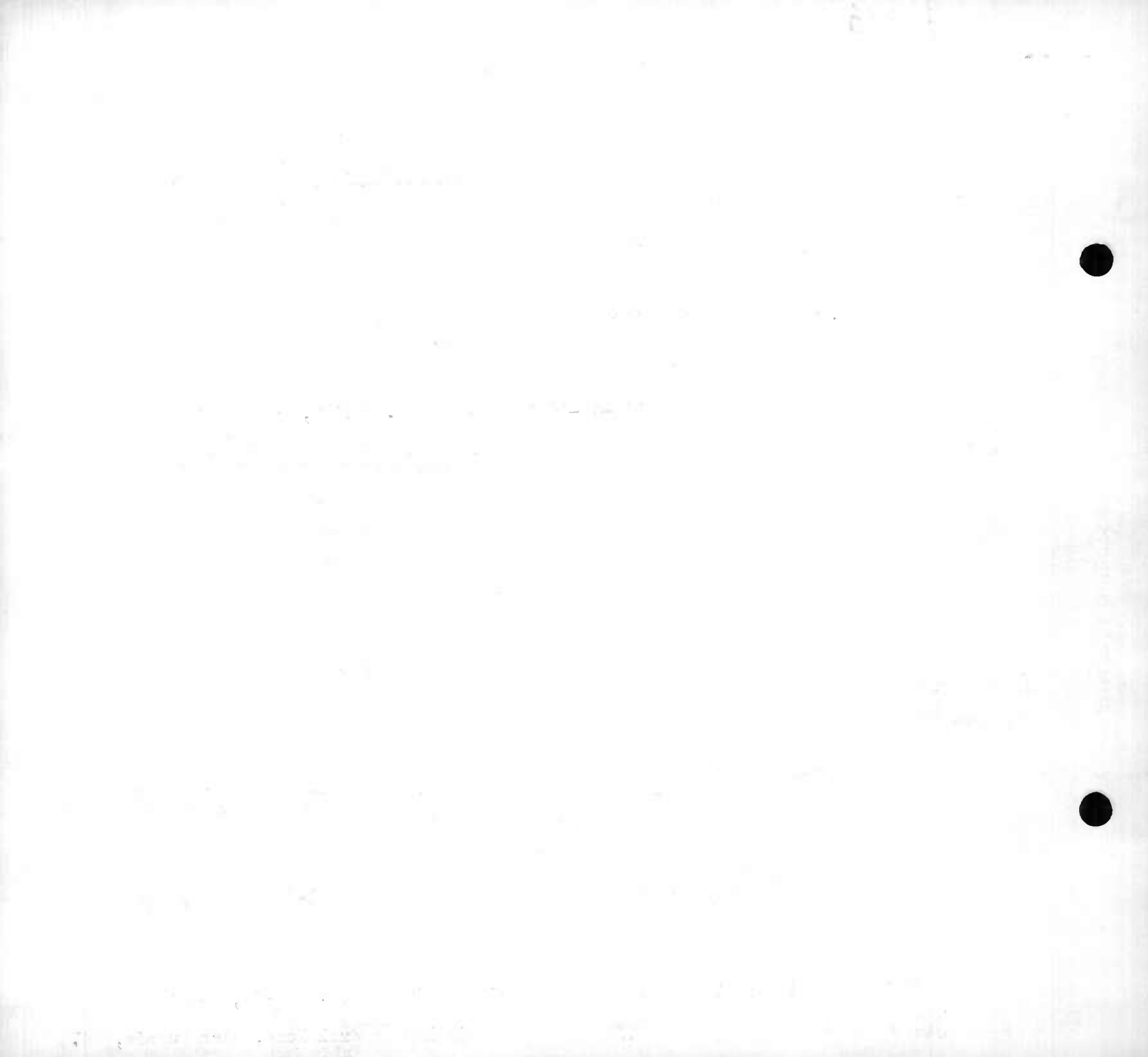




# FUNERAL DIRECTOR: IMPORTANT

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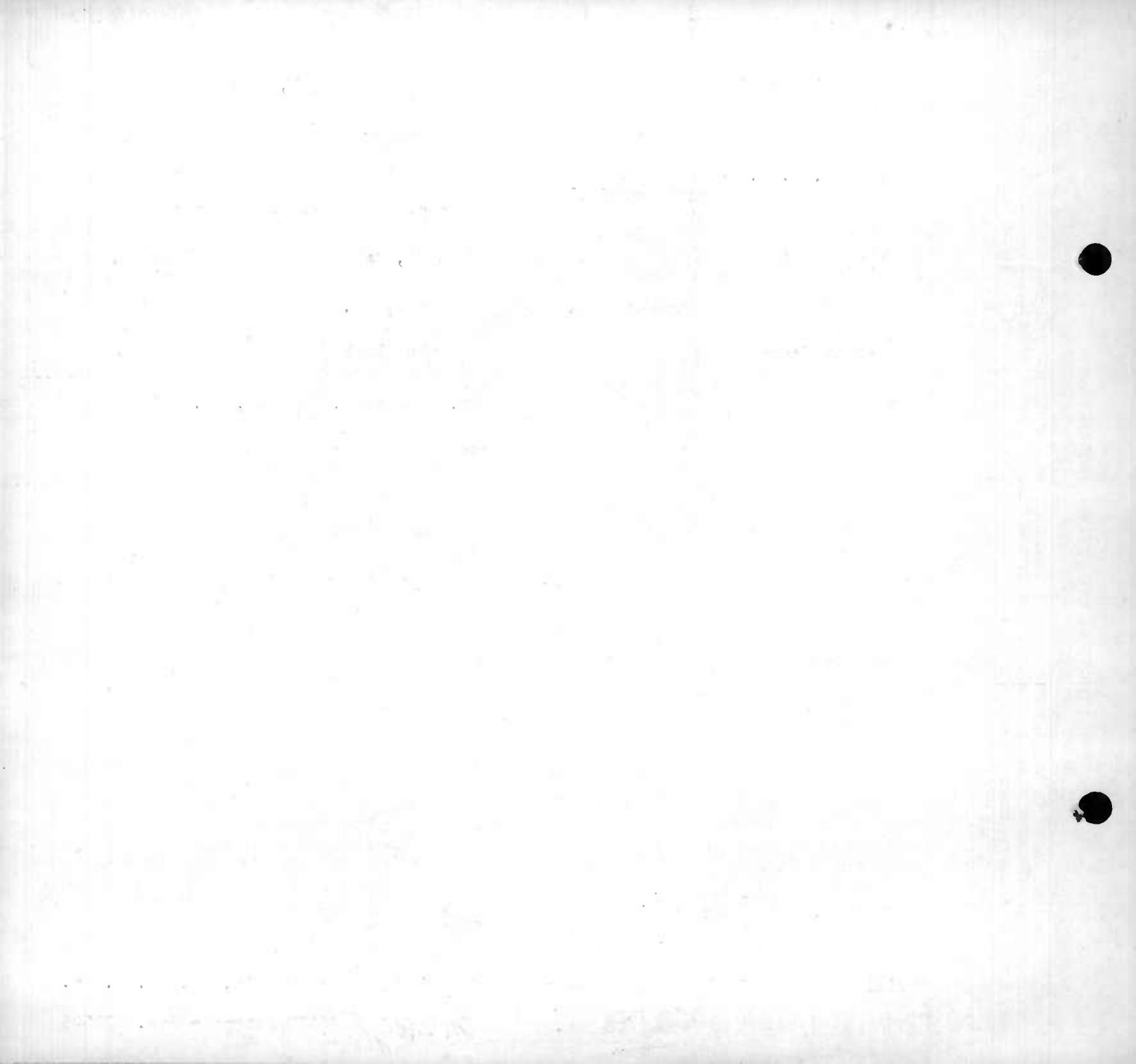
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5884</span>	
A-325 70 5884		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ATKINS JENNIE E.</b>		2. DATE AND HOUR OF DEATH <b>6/6/70</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>A.A.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Glen Burnie</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		8. DATE OF BIRTH <b>06/24/14</b> 9. AGE (In years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Michael Gangemi</b>		14. MOTHER'S MAIDEN NAME <b>Marie Constanza</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>243-16-4683</b>		17. INFORMANT <b>George H. Atkins, same as 4.</b>	
18. <b>5-19-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiopulmonary failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>no</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-19</b> 19 <b>70</b> to <b>6-6</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6-6</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lucas C. Wallingford</i>				23B. DATE SIGNED <b>6-6-70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10 June 70</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 9 1970</b>			
25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5885</span>	
<div style="font-size: 1.5em; font-weight: bold;">U-46570 5885</div> <div style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Cirdie Mildred Uhlhorn			June 7, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em;">43</div> <div style="font-size: 1.5em;">99</div> D. O. A. South Baltimore General Hospital			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2025 Annapolis Road 21230		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 27, 1893	76	Saleslady
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Brager Dept. Store			Senora, Va.		U S
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Everett Dodson			Lula Clark		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					21230
			Mr. Charles P. Uhlhorn, Sr. 2025 Annapolis Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Diabetes Mellitus - 2 years A.C.U.D. - Decompensated - 1 day Senile Psychosis - 2 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Paul Schmidt				6/8/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				7301 Annapolis Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/10/70		Glen Haven Memorial Pk	
				Glen Burnie, Md. A. A. Co.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1970		Robert E. Fisher, Jr.		McGally F.H. 237 Patapsco Ave. 21225	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. <span style="font-size: 2em;">70 5886</span>	
V-240 <span style="font-size: 2em;">70 5886</span>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">JESSIE M. VOGEL</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6-5-70</span> <span style="font-size: 1.5em;">9:40 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Union Memorial Hospital Calvert &amp; 33rd St. Balt Md</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">HARFORD</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Havre de Grace</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">Westwood Manor</span>	
5. SEX <span style="font-size: 1.5em;">F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Sept. 28, 1880</span> 9. AGE (In years lost birthday) <span style="font-size: 1.2em;">89</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Home</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Kentucky</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Jesse Wareland</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Treutter</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-46-1312</span>		17. INFORMANT <span style="font-size: 1.2em;">Margaret A. Bowden, Havre de Grace, Md.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Terminal Heart Failure</span> (B) CHRONIC DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Recto-vaginal fistula</span> <span style="font-size: 1.5em;">Chronic Intestinal obstruction 2° to radiation</span> (C) RECURRENT DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">CANCER</span> <span style="font-size: 1.5em;">Recurrent Cancer of Cervix</span>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">10 days</span> <span style="font-size: 1.5em;">2 mos</span> <span style="font-size: 1.5em;">2 mos</span> <span style="font-size: 1.5em;">6 YEARS</span>		AGE <span style="font-size: 1.5em;">89+ yrs</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">JAN. 70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">CANCER</span>	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-26-</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6-5-</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">6-5-</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">John H. Hebb</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">6/6/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOHN H. HEBB MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">8413 LOCKRAVER BLVD.; BALTO 21202 MD.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Removal-Burial</span>	24B. DATE <span style="font-size: 1.2em;">6-8-70</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Forest Home Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Milwaukee, Wisconsin</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 9 1970</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, Md.</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Tarring Funeral Home Aberdeen, Md. 21001</span>	

(45)

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# CERTIFICATE AMENDED

1. NAME OF DECEASED (Type or Print) Mrs. Nera <del>Laramore</del> Denson		2. DATE AND HOUR OF DEATH June 5, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED (If not in hospital or institution, give street address or location) 00 3005 W. Coldspring Lane.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1513	
5. SEX Female	6. RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 94
13. FATHER'S NAME Cadamus H. Laramore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		14. MOTHER'S MAIDEN NAME Mary Ann Dickerson	
16. SOCIAL SECURITY NO. 216-03-1750		17. INFORMANT Mr. Dick Higgins 6018 Lakeview Rd. 21210	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) Antecedent Causes DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (C) Other Significant Conditions Contributing to the Death but not related to the terminal disease or condition given in Part I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/4/61 19 to 6/5/70 19 that (I) (we) last saw the deceased alive on June 5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Willard Applefeld MD.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 6615 Reisterstown Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/70	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd. Randallstown	

VS153 6-9-70 KMH.

Edward B. Perry

June 2

8/14/01

8/22/20

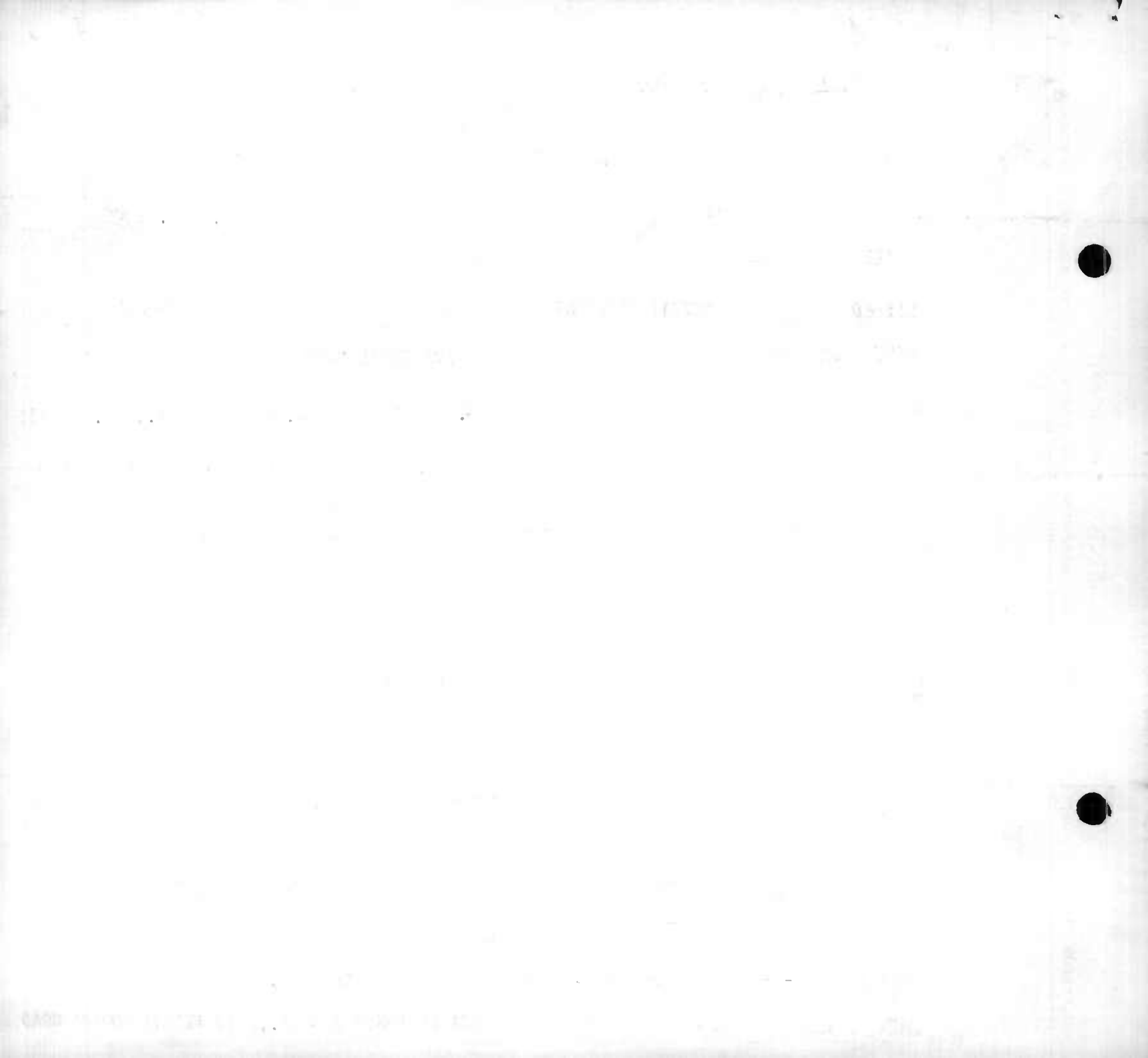
Gen. Edward B. Perry  
Superintendent CMAA  
Carter's West Building  
Columbia, Missouri



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

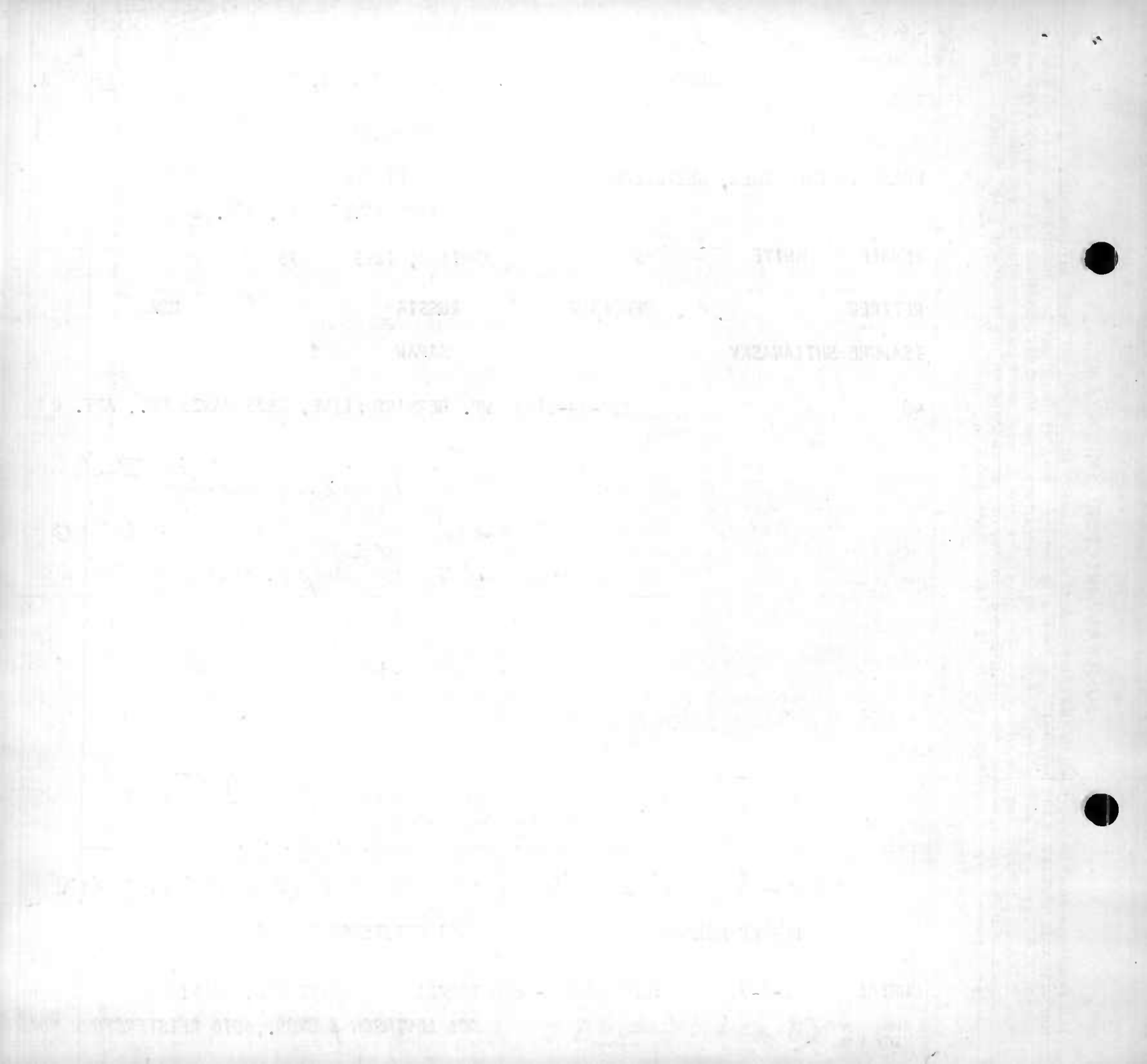
BALTIMORE CITY HEALTH DEPARTMENT				X		70 5888	
BIRTH NO. 8-232 70 5888				CERTIFICATE OF DEATH		REG. NO. 70 5888	
1. NAME OF DECEASED (Type or Print) <b>Solomon Bukowitz</b>				2. DATE AND HOUR OF DEATH <b>6-7-70</b> <b>11</b> <b>P</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL of BALTIMORE, INC.</b> <b>42</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>5300</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>4 AMLEIGH COURT, APT. 2 C</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-99</b>	9. AGE (In years last birthday) <b>70</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>MAYER BUKOWITZ</b>				14. MOTHER'S MAIDEN NAME <b>DINA REMALOFKY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO?</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>MRS. DORIS BUKOWITZ, 4 AMLEHT CT., APT. 2C #15</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>600 X 1 250.9</b> <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HEMORRHOID FROM PROSTATIC HYPERTROPHY</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDIAL INFARCTION</b> (B) <del>HEMORRHOID</del> <b>PROSTATIC HYPERTROPHY</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HOURS</b> <b>?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>Diabetes Mellitus.</b>							
19A. DATE OF OPERATION <b>6-7-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BLEEDING BPH</b>		20A. AUTOPSY? (Yes or No) <b>None</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-21</b> 19 <b>70</b> to <b>6-7</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6-7</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I did) (did not) view the body after death.							
23A. SIGNATURE <b>Leslie Abramowitz M.D.</b>				23B. DATE SIGNED <b>6/7/70</b>		23C. PHYSICIAN'S NAME (Type) <b>LESLIE ABRAMOWITZ M.D.</b>	
23D. ADDRESS <b>SINAI HOSP. of BALTIMORE, INC.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-9-70</b>		24C. NAME of CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death, shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

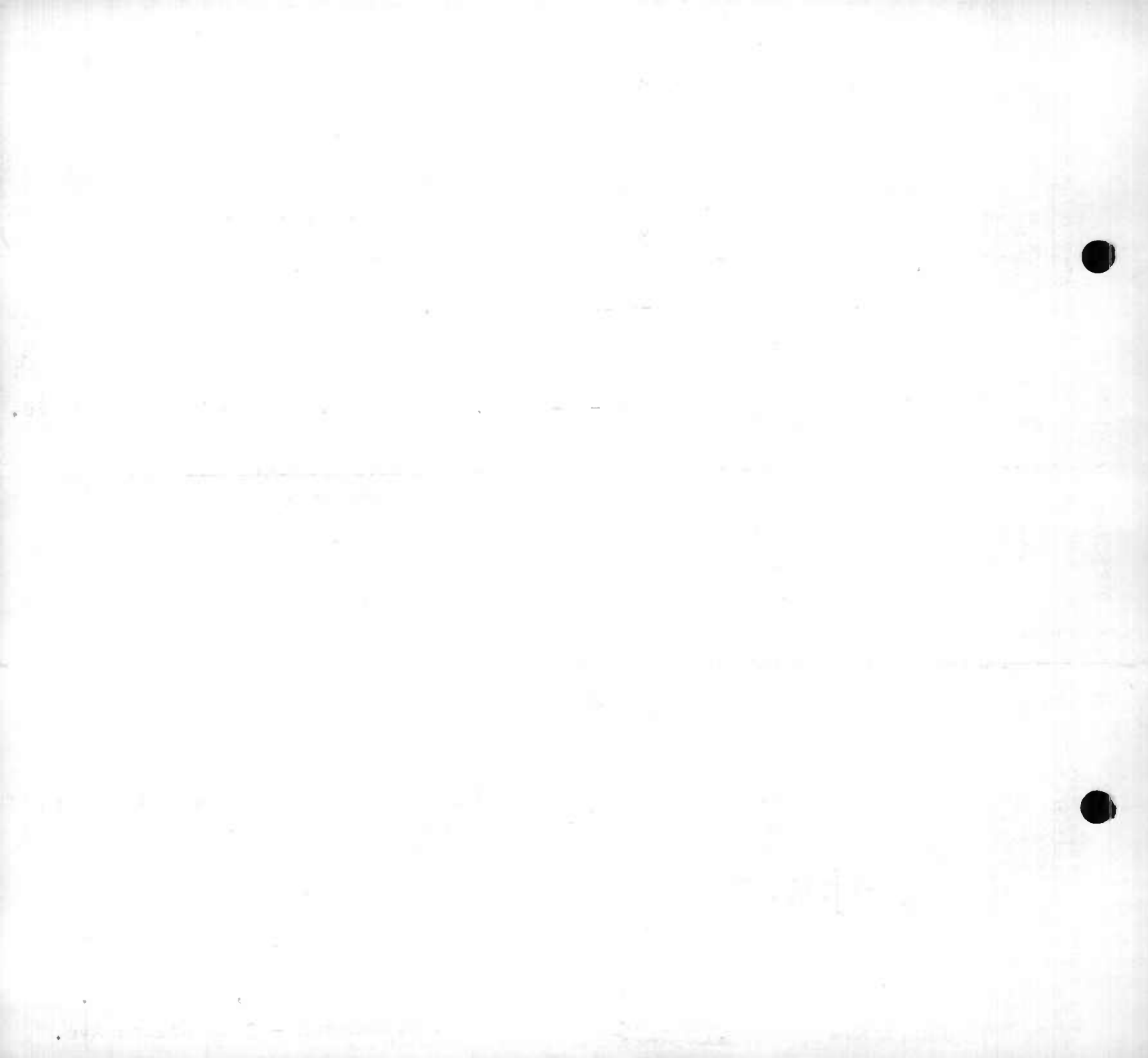
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 70 5889									
BIRTH NO. <b>X-256</b>		1. NAME OF DECEASED (Type or Print) <b>REBECCA KEISNER</b>		2. DATE AND HOUR OF DEATH <b>JUNE 8, 1970</b>		3:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOUSE IN THE PINES, BELVEDERE</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>6505 SANZO ROAD, APT. C</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 6, 1895</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ISADORE SHILANASKY</b>			14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-44-2190</b>		17. INFORMANT ADDRESS <b>MR. BERNARD KLINE, 6505 SANZO RD., APT. C</b>					
18. <b>174 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of Respiratory failure with pneumonia</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple Myeloma</b> (C) <b>Multiple Myeloma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Yr. 6 mo</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>April 21, 1970</b> to <b>June 8, 1970</b> , that (I) (we) last saw the deceased alive on <b>June 5, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Lester Kolman</b>				23B. DATE SIGNED <b>6/8/70</b>		23C. PHYSICIAN'S NAME (Type) <b>LESTER KOLMAN</b>			
23D. ADDRESS <b>6821 REISTERSTOWN ROAD</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-9-70</b>		24C. NAME of CEMETERY or CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

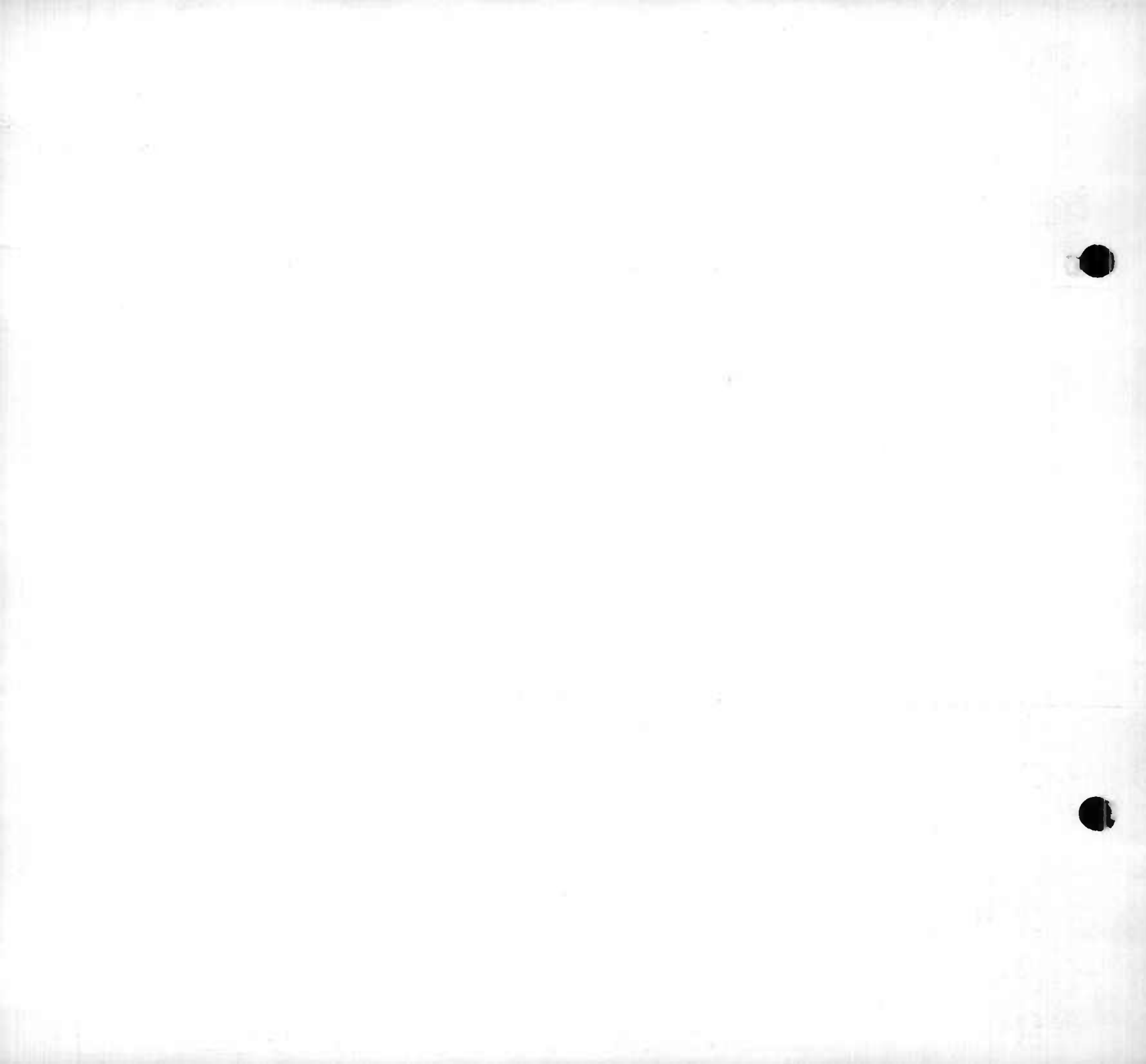
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5890</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">K-450</span>		<b>70 5890</b>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">KLINE LAURA</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">6/7/1970 11 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND.</span> B. COUNTY <span style="font-size: 1.2em;">1307</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">Six 3662 Koswick Road 21211</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">8/4/80</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">89</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">-----</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">David Six</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-09-6057</span>			<b>17. INFORMANT</b> ADDRESS <span style="font-size: 1.2em;">B. Charles P. Kline -3662 Koswick Rd.</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">CORONARY INSUFFICIENCY</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">Possible M.I.</span>   <b>(B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>   <b>(C) -----</b> </div> </div>					
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <span style="font-size: 1.2em;">II</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">6/4</span> <span style="font-size: 1.2em;">1970</span> <b>to</b> <span style="font-size: 1.2em;">6/7</span> <span style="font-size: 1.2em;">1970</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">6/7</span> <span style="font-size: 1.2em;">1970</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">M.P.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6/7/1970</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">ANDREAS A. PETSAS</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE.</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6/10/70</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Woodlawn Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 10 1970</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>			
<b>25C. FUNERAL DIRECTOR</b> ADDRESS <span style="font-size: 1.2em;">Ann Donovan - 3818 Roland Ave.</span>					



# FUNERAL DIRECTOR: IMPORTANT

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W-324 70 5891		BALTIMORE CITY HEALTH DEPARTMENT		70 5891	
BIRTH NO. WEITZELL		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LILLIAN BELLE WEITZELL</b>			2. DATE AND HOUR OF DEATH <b>June 8, 1970 3:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2302</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>			6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5-27-91</b>		9. AGE (In years last birthday) <b>79 yrs.</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>James Monroe Jamerson (dec.)</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth T. (dec.) Virginia</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-03-855</b>		17. INFORMANT <b>William Lloyd Weitzell same</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrhythmia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myocardial infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 6</b> 19 <b>70</b> to <b>June 8</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>June 8</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virginia Faust - Mercado, M.D.</b>				23B. DATE SIGNED <b>June 8, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA FAUST - MERCADO, M.D.</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>13</b>		24B. DATE <b>6-11-70</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTO. NAT</b>	
24D. LOCATION <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Kelly, Jr.</b>		25C. FUNERAL DIRECTOR <b>Robert E. Kelly, Jr.</b>			
ADDRESS <b>130 E. Fort St.</b>					

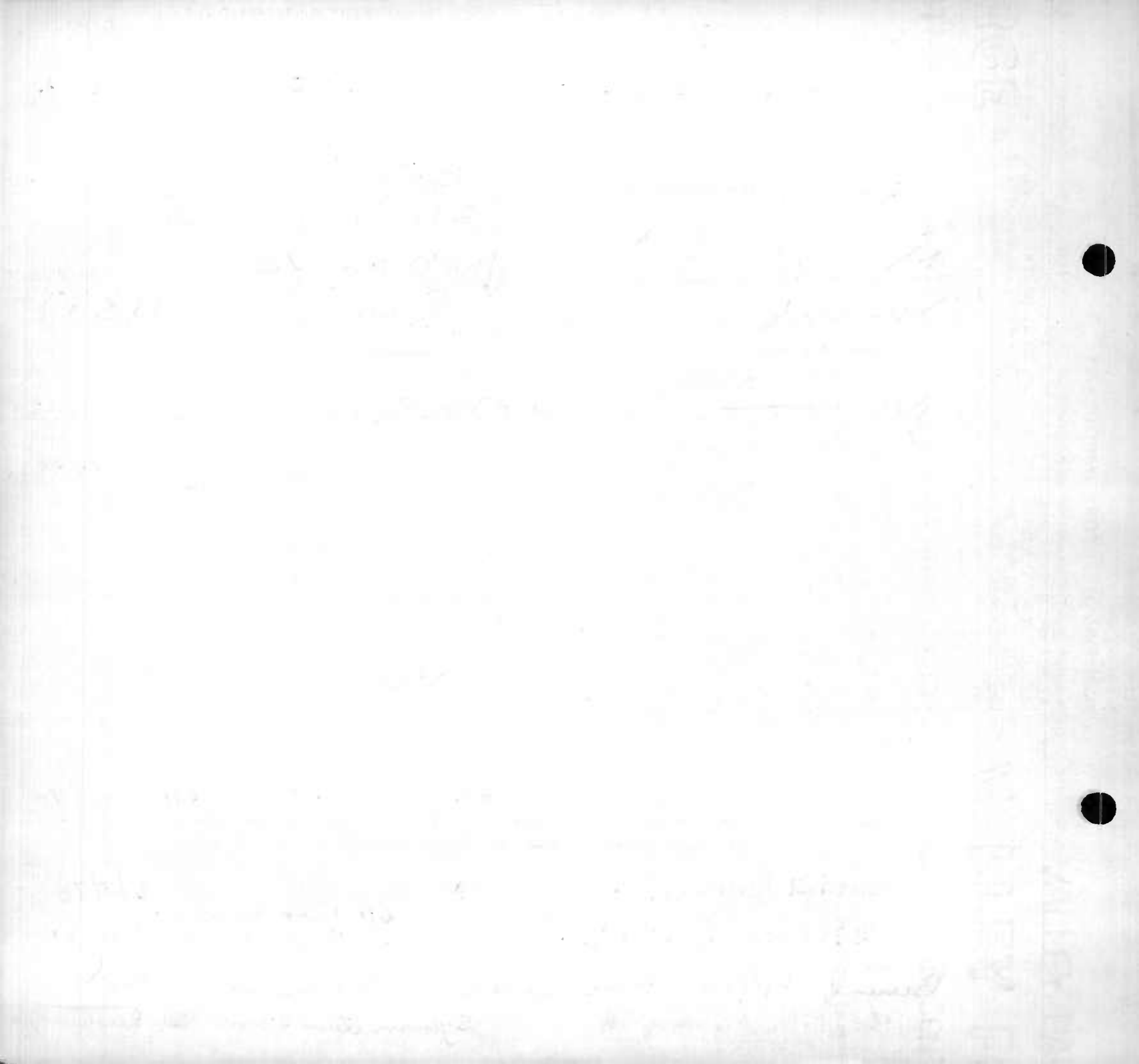




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5892	
BIRTH NO. S-4/6 70 5892		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PHILIP SILVERMAN		2. DATE AND HOUR OF DEATH JUNE 5, 1970 10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2401 MARYLAND AVE		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 13, 1946		9. AGE (In years last birthday) 23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-14-3874	
17. INFORMANT Mrs. Florence Silverman		ADDRESS Same		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from JAN. 1968 to 6/1 1970, that (I) (we) last saw the deceased alive on 6/1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Barnett Berman, M.D.		23B. DATE SIGNED 6/5/70		23C. PHYSICIAN'S NAME (Type) BARNETT BERMAN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/70		24C. NAME OF CEMETERY or CREMATORY Hae Sinai	
24D. LOCATION Baltimore, Maryland		24E. CITY, town, or county Md		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan Lewis & Son	
25D. ADDRESS 9610 Reisterstown Rd					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 5893	
CERTIFICATE OF DEATH				REG. NO. 70 5893	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Robinson BABY BOY		6/9/70 6:10 a.m.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2719	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/8/70		9. AGE (In years last birthday) 14		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME LEIZER	
14. MOTHER'S MAIDEN NAME DEBBY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Apneic episode		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) UNDETERMINED CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/8/70 19 to 6/9/70 19 that (I) (we) last saw the deceased alive on 6/8/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Rabstein		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Jorge SRABSTEIN, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/9/70		24C. NAME OF CEMETERY OR CREMATORY Shalom Israel	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT JUN 10 1970		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Sylvan [unclear] & Son		25D. ADDRESS 9610 Reisterstown Rd			

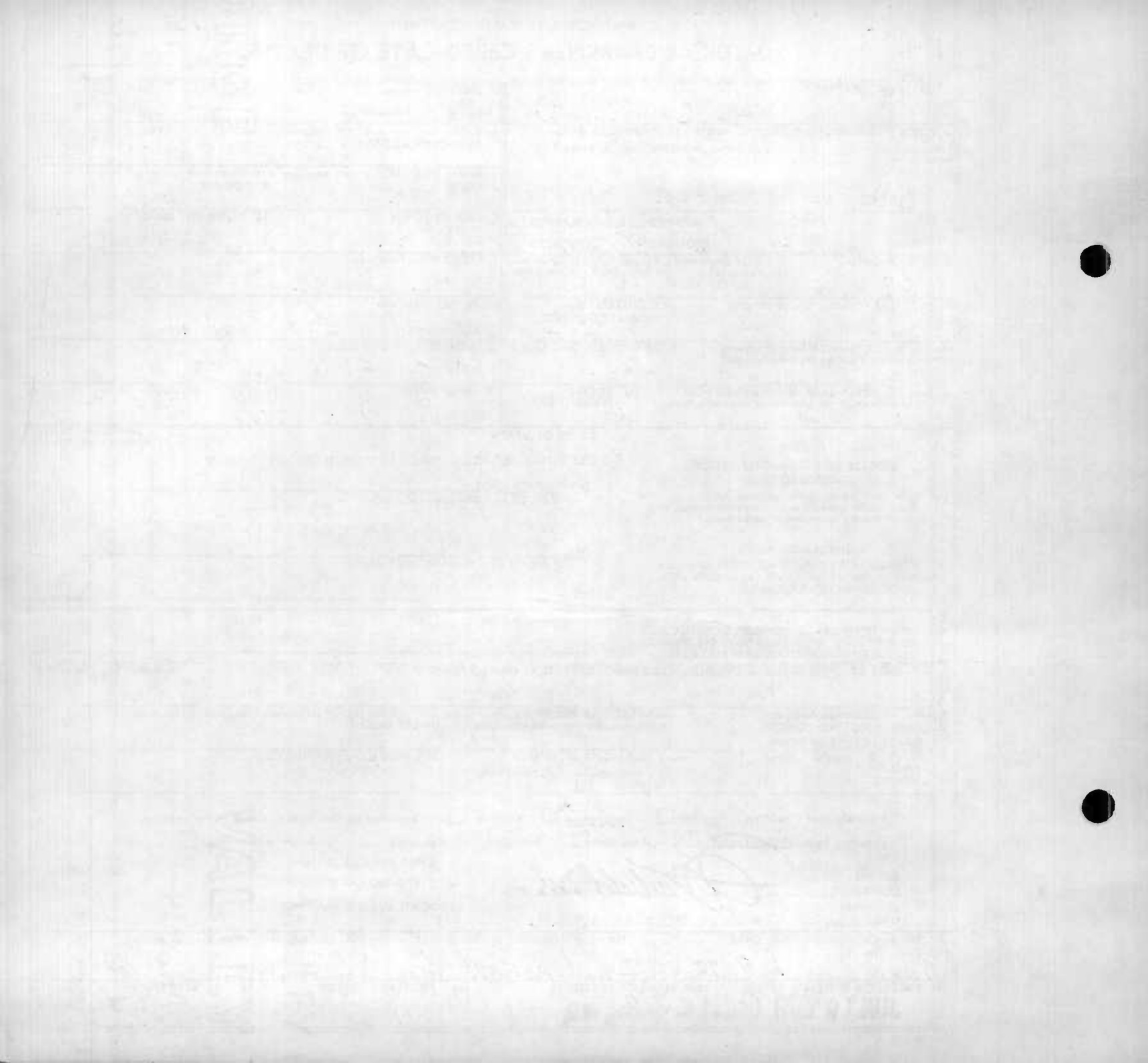


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANK DEHAVEN (FRANKLIN T.)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>125 S. Gilmore St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 6 1970 1:15 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>2/27/1900</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel De Haven</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cat Buyer</b>	
15. MOTHER'S MAIDEN NAME <b>Ada E. Clarke</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>7-11-11111</b>		18. INFORMANT <b>Mrs. Flora Becraft</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>6/9/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6-6-70</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>6/9/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>London Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John J. Garavito Inc.</b>	
ADDRESS <b>991 St. Hollins</b>		25D. ADDRESS <b>23, Md.</b>	



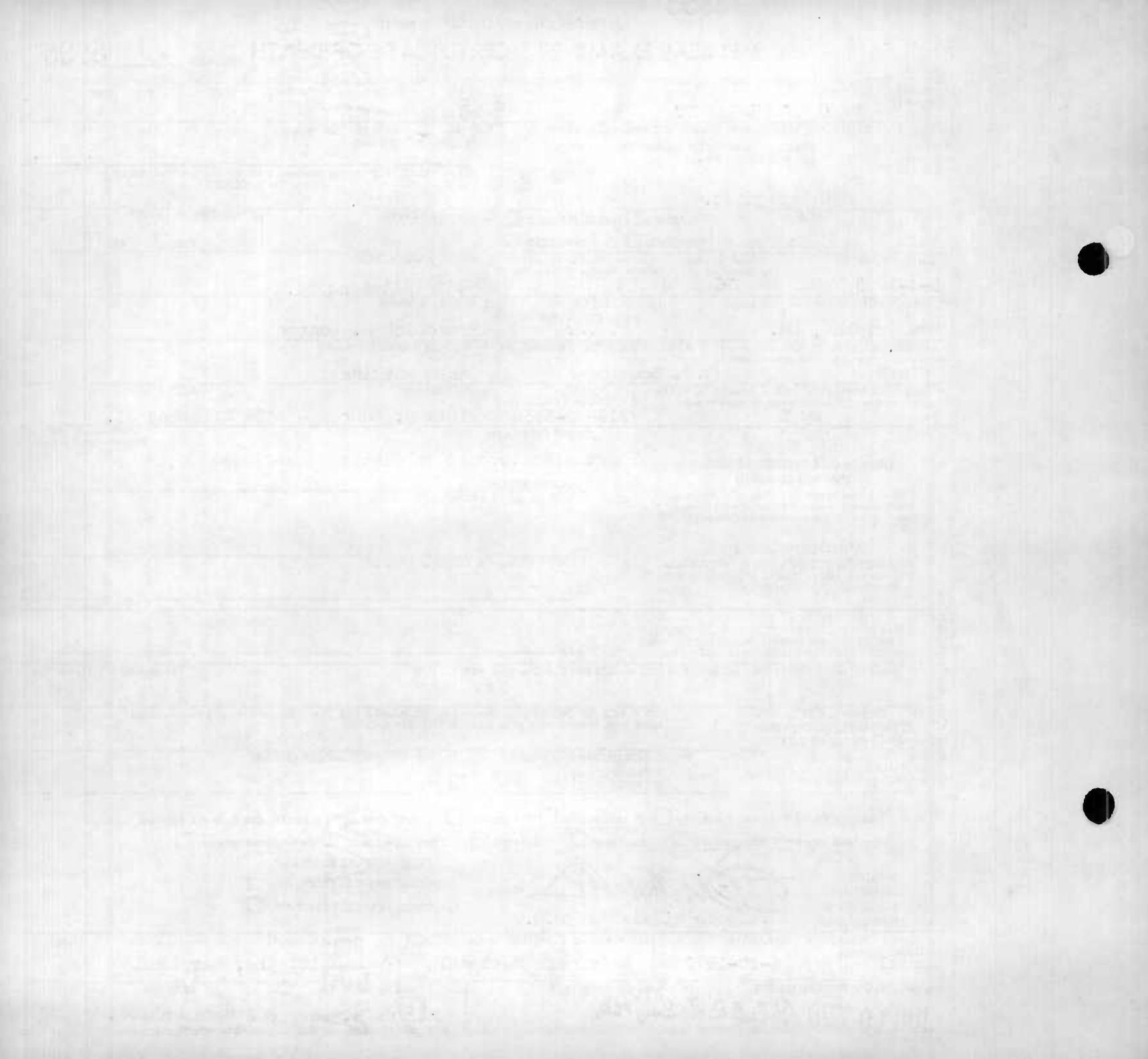
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5895

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LOUIS CLAUDE BUNTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>226 Ellamont St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 6 1970 9:15 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1537</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-4-1893</b>	10. AGE (In years lost birthday) <b>76</b>	11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick H. Bunton</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		15. MOTHER'S MAIDEN NAME <b>Sarah Watkins</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		17. SOCIAL SECURITY NO. <b>215-01-5550</b>	
18. INFORMANT ADDRESS <b>Viola M. Bunton - 2426 Ellamont St.</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>NO</b>		22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22E. HOW DID INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6-7-70</b>		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>6-10-1970</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Charles R. Law</b>	ADDRESS <b>802 Madison Ave.</b>

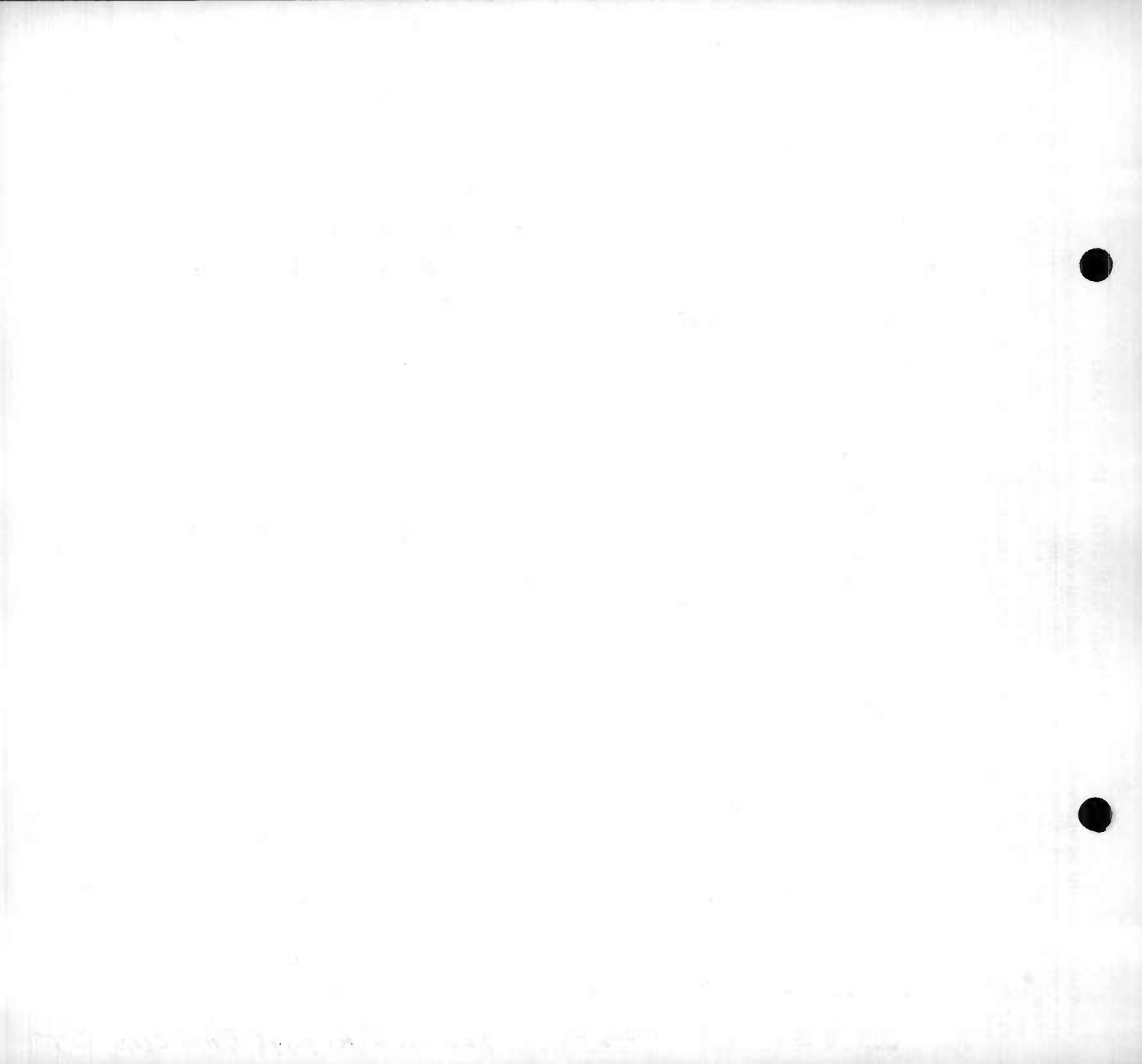




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

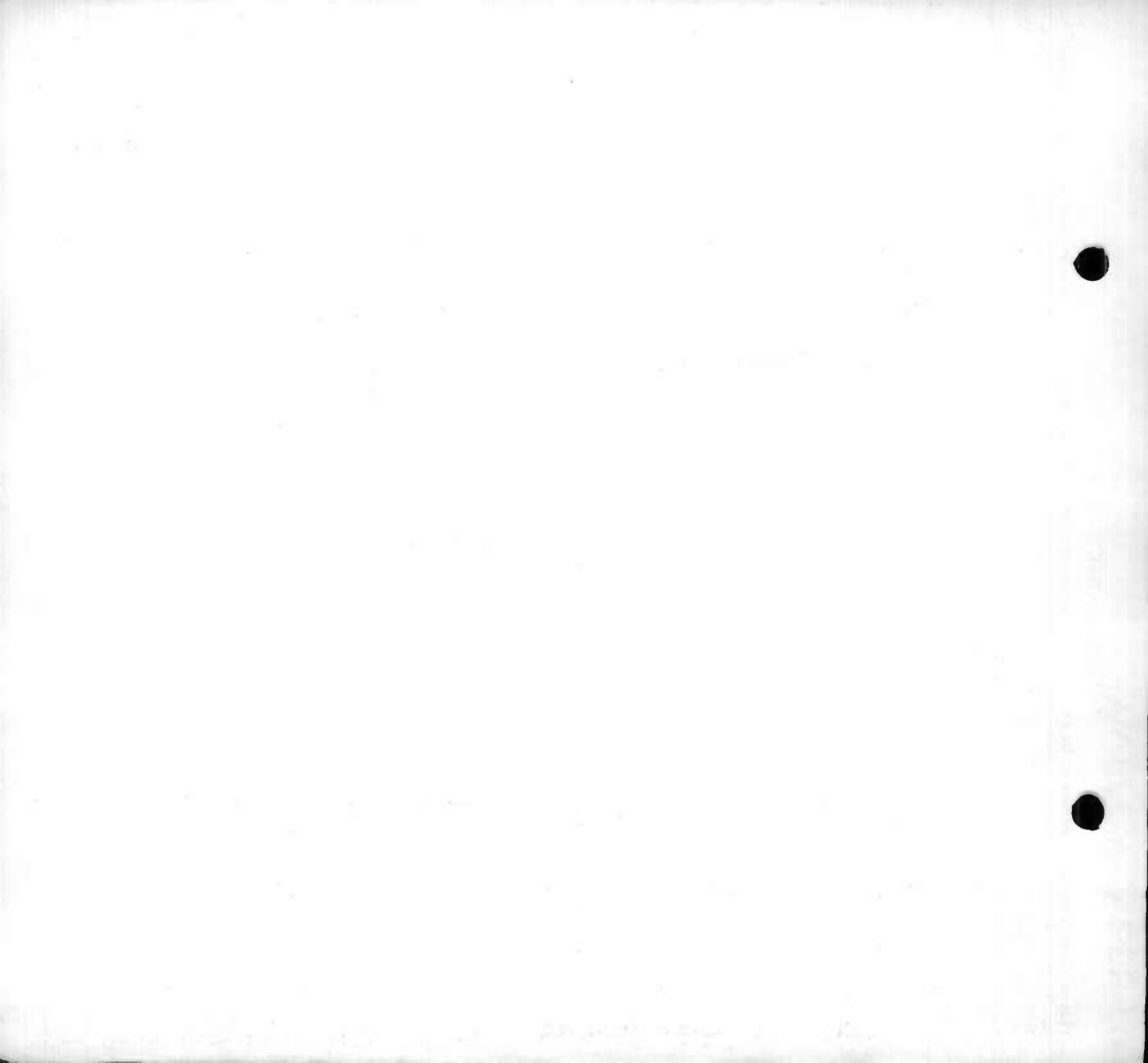
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5896	
BIRTH NO. 70 5896		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type, Print) <b>PATTERSON, JESSIE</b>		2. DATE AND HOUR OF DEATH <b>6-8-70 905 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1502</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN Hosp</b>		C. CITY OR TOWN <b>Balt.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1810 PRESBURY ST.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-1899 71</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LUTHERAN HOSP.</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
13. FATHER'S NAME <b>Link PATTERSON</b>		14. MOTHER'S MAIDEN NAME <b>EFFIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>042-09-3906</b>		17. INFORMANT <b>MARY PATTERSON</b> ADDRESS <b>SAME</b>	
18. <b>4-10-9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: <b>acute coronary occlusion 2 wks.</b> (B) <b>ascro with CHF</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>week</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> 19 <b>70</b> to <b>6/8</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/8</b> 19 <b>70</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elmore J. Gayoso</b>		DEGREE		23B. DATE SIGNED <b>6/8/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Elmore J. Gayoso</b>		23D. ADDRESS <b>Lutheran Hosp. of MD. 2426</b>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>BURIAL 6/12/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>V. BAILEY</b> ADDRESS <b>KEELSON E. H. 1348 CALHOUN ST.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

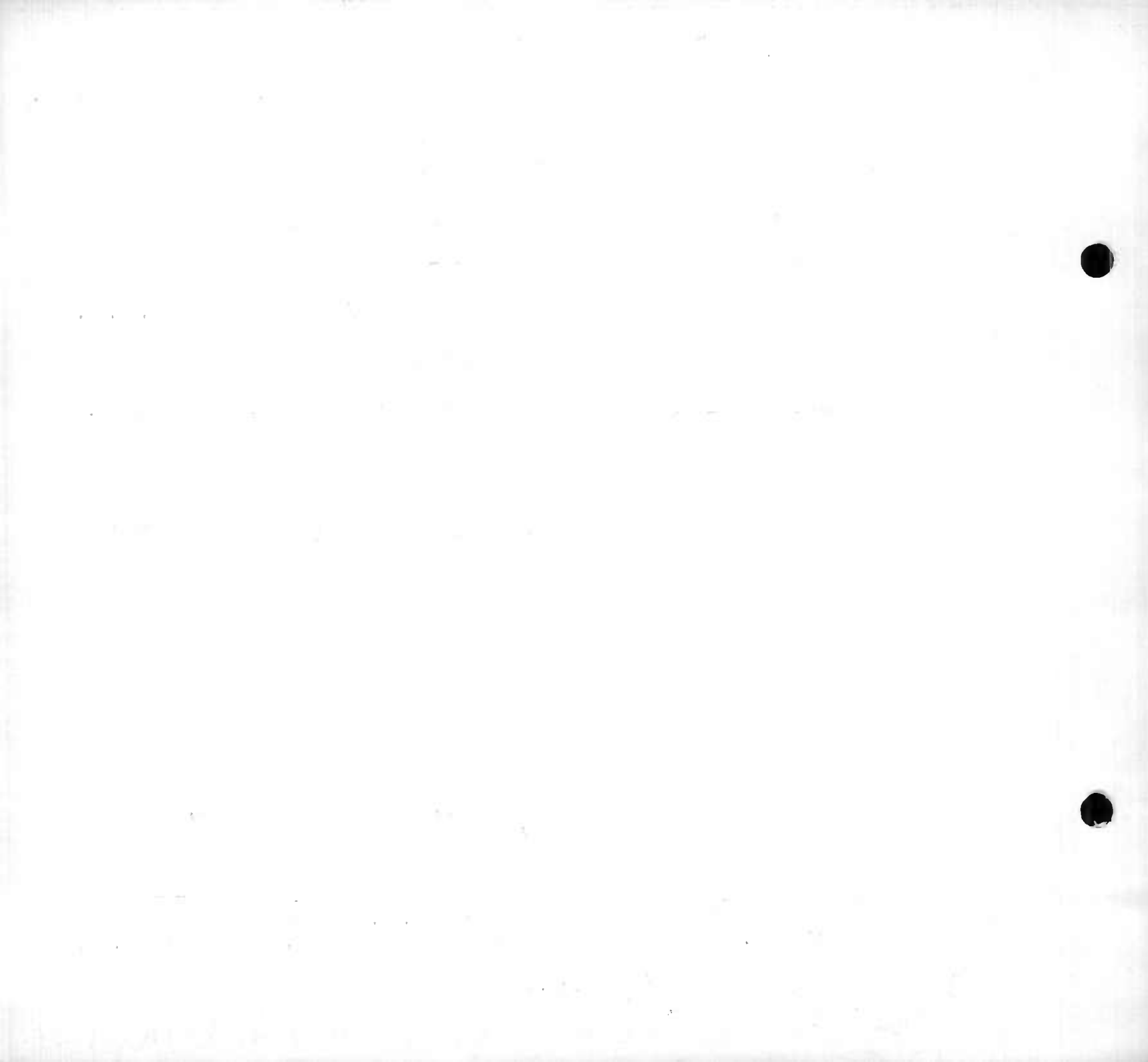
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5897	
BIRTH NO. 70 5897		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARGARET C. HEWLIN</u>		2. DATE AND HOUR OF DEATH <u>6-8-70</u> <u>1-10</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>908</u> C. CITY OR TOWN <u>BALTO - MD</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>327 HAYWOOD AVE.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-20</u>	9. AGE (In years last birthday) <u>49</u>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Susie Richardson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elaine Conway</u> ADDRESS <u>1618 E. 31st. St.</u>	
18. <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PNEUMONITIS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOMA OF RT. LUNG.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (N) (this hospital) attended the deceased from <u>6/7 1970</u> to <u>6/8 1970</u> and that (N) (we) last saw the deceased alive on <u>6/8 1970</u> and that (N) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did not) view the body after death.			
23A. SIGNATURE <u>Patrick A. Molony MD</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>PATRICK A. MOLONY MD</u>	
23D. ADDRESS		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-12-70</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cem</u>	
24D. LOCATION (City, town, or county) <u>Balto. Ind.</u>		24E. STATE (State) <u>MD</u>		24F. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1970</u>	
24G. NAME OF REGISTRAR <u>John E. Jaber, MD</u>		24H. FUNERAL DIRECTOR <u>U. Bailey</u>		24I. ADDRESS <u>Kellogg Bldg. 1348 Calhoun St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5898		REG. NO. 70 5898	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HORNE, DANIEL (NMI)		June 6, 1969 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Veterans Administration Hospital				Maryland		Baltimore	
23 3900 Loch Raven Boulevard				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore, Maryland 21218				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male				Negroid		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Contractor				Unknown		3-6-10	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
Amos Horne				Unknown Crecy Cobb		60	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes 1-10-44 to 9-15-44				239-24-1552		Records Veterans	
				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				North Carolina		U. S. A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE		2 Days	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic Heart Disease		10 Years	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from June 5, 19 70 to June 6, 19 70 that (X) (we) last saw the deceased alive on June 6, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Hubert T. Gurley				6-7-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
HUBERT T. GURLEY MD				V. A. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				6-11-70		Balto. Nat'l. Cem.	
24D. LOCATION (City, town, or county) (State)				24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Balto. Md.				JUN 10 1970		V. E. Taylor, M.D.	
25A. FUNERAL DIRECTOR				25B. ADDRESS			
V. BAILEY				Kelson B. H. 1348 Calhoun St.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5899</b>	
BIRTH NO. <b>70 5899</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, BEULAH</b>		2. DATE AND HOUR OF DEATH <b>7 June 1970 6:00 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>603</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>GOOD SAMARITAN HOSP</b>		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>205 N. COLLINGTON AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>N N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-07</b>	9. AGE (In years lost birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Brooks Wms.</b>	
				ADDRESS <b>Same</b>	
18. <b>5710 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>LAENNEC'S CIRRHOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost, <b>ALCOHOLISM</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ALCOHOLISM</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>YRS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>RENAL FAILURE</b>				<b>3 DAYS</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>5/26</b> 19 <b>70</b> to <b>6/7</b> 19 <b>70</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>6/7</b> 19 <b>70</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Matthew Pollack MD</b>				23B. DATE SIGNED <b>7 June 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Johns Hopkins Hospital Balto MD</b>				23D. ADDRESS <b>1318 CALHOUN ST.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-10-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. AUBURN CEM.</b>	
24D. LOCATION <b>BALTO. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>	
25C. FUNERAL DIRECTOR <b>V. BAILEY</b>		25D. ADDRESS <b>1318 CALHOUN ST.</b>			

WILLIAM H. H.

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WILLIAM H. H.

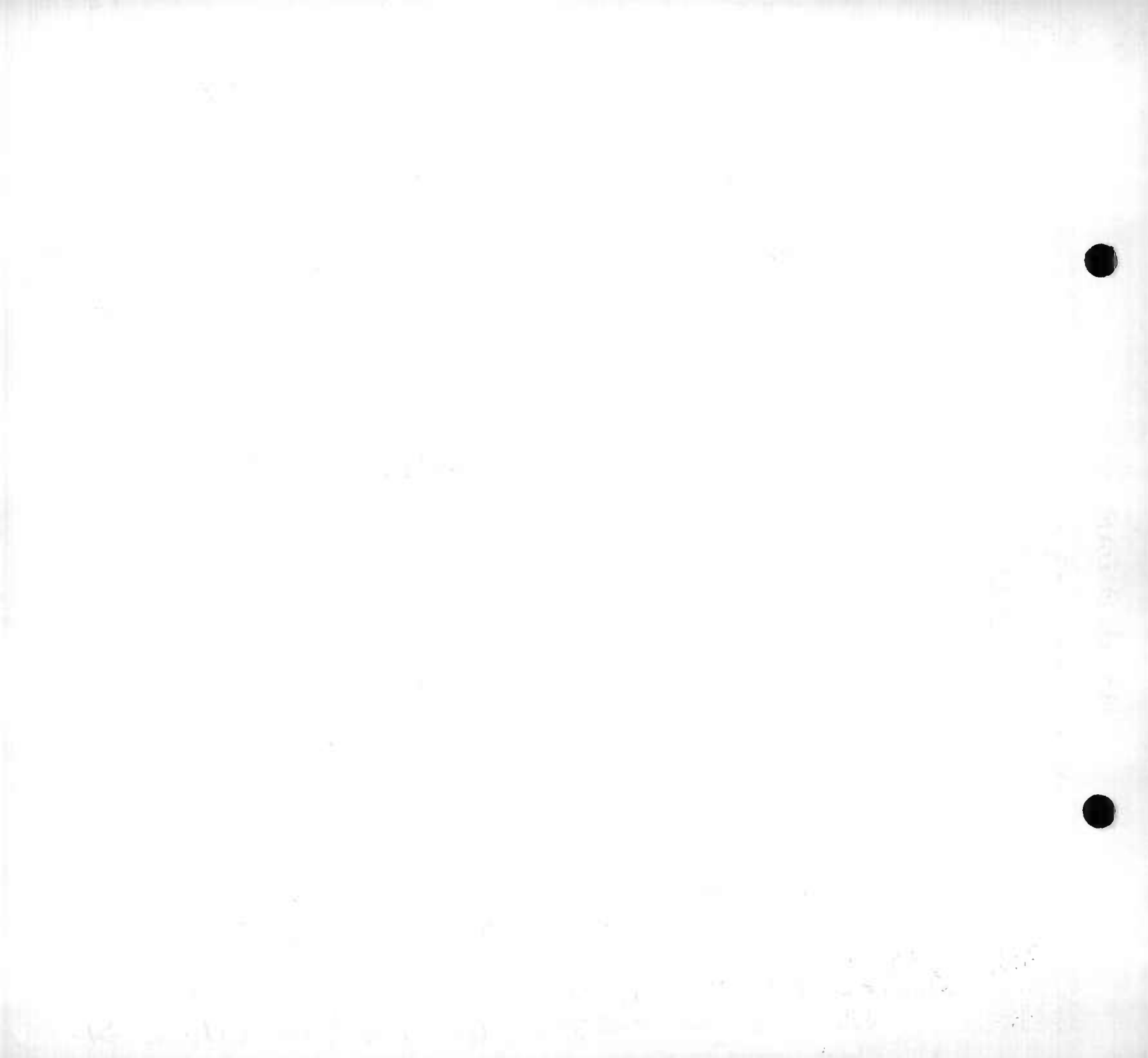
WILLIAM H. H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5900	
BIRTH NO.		70 5900		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) WILLIAM P. WALKER		2. DATE AND HOUR OF DEATH 3:30 pm 6/7/70 3:30 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission) A. STATE Md. B. COUNTY 1202			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
5. SEX male		6. RACE negroid		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-95		9. AGE (in years last birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY Gillman Apartments		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME FRED. WALKER		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE ANNIE WALKER	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4:53 am 6-7 1970 to 6/7 1970 that (I) (we) lost saw the deceased alive on 3:25 pm 6-7 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. P. W. Kammen M.D.		23B. DATE SIGNED 6/7 70		23C. PHYSICIAN'S NAME (Type) D.P. W. KAMMEN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR V. Bailey	
25D. ADDRESS 1348 Calhoun St.		25E. ADDRESS			



J-520

70 5901

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5901

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANTHONY E. JONES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>6 6 1970 9:45 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negroid</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1-25-51</b>		10. AGE (In years last birthday) <b>19</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Job Corps.</b>		15. MOTHER'S MAIDEN NAME <b>Helen R. Wimbush</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Ralph Wimbush - sam</b>		ADDRESS	
19. <b>304.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Intravenous narcotism</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6-7-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-10-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>KELSON F. H.</b>		ADDRESS <b>1348 Calhoun St.</b>	


69 S. Morley St.

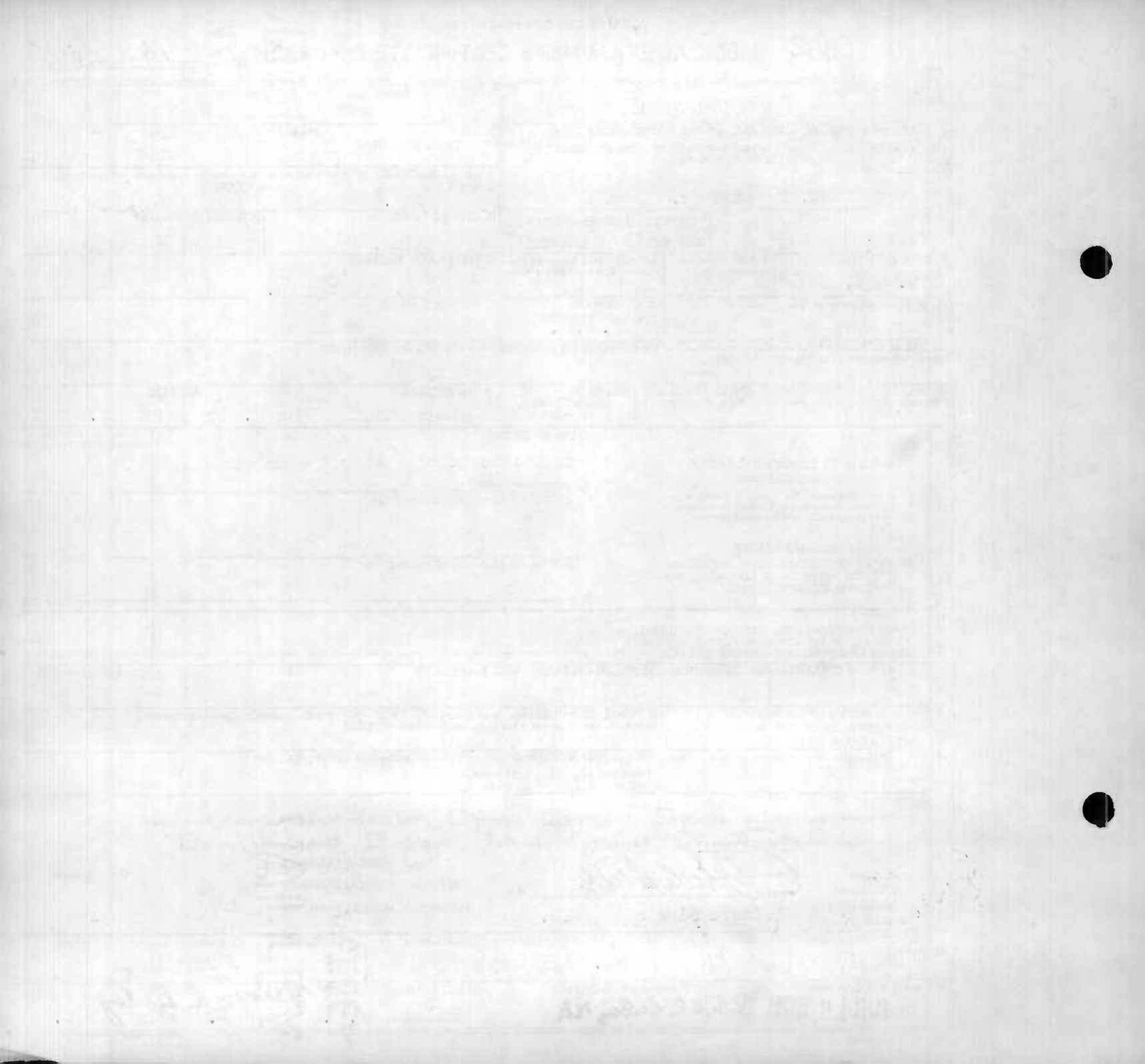
70 5902

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5902

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALICE DUVAL L</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 912 E. Preston St.</b>		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour		
				6	6	1970	3:55 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md.		B. COUNTY <b>909</b>						
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH Nov. 23, 1908		10. AGE (In years lost birthday) 61		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 912 E. Preston St.		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Duval				
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Nevett				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 21922-2227		18. INFORMANT ADDRESS James Duval 912 E. Preston St.				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE  M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 6-7-70								
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/70		24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 N. Calhoun St.				



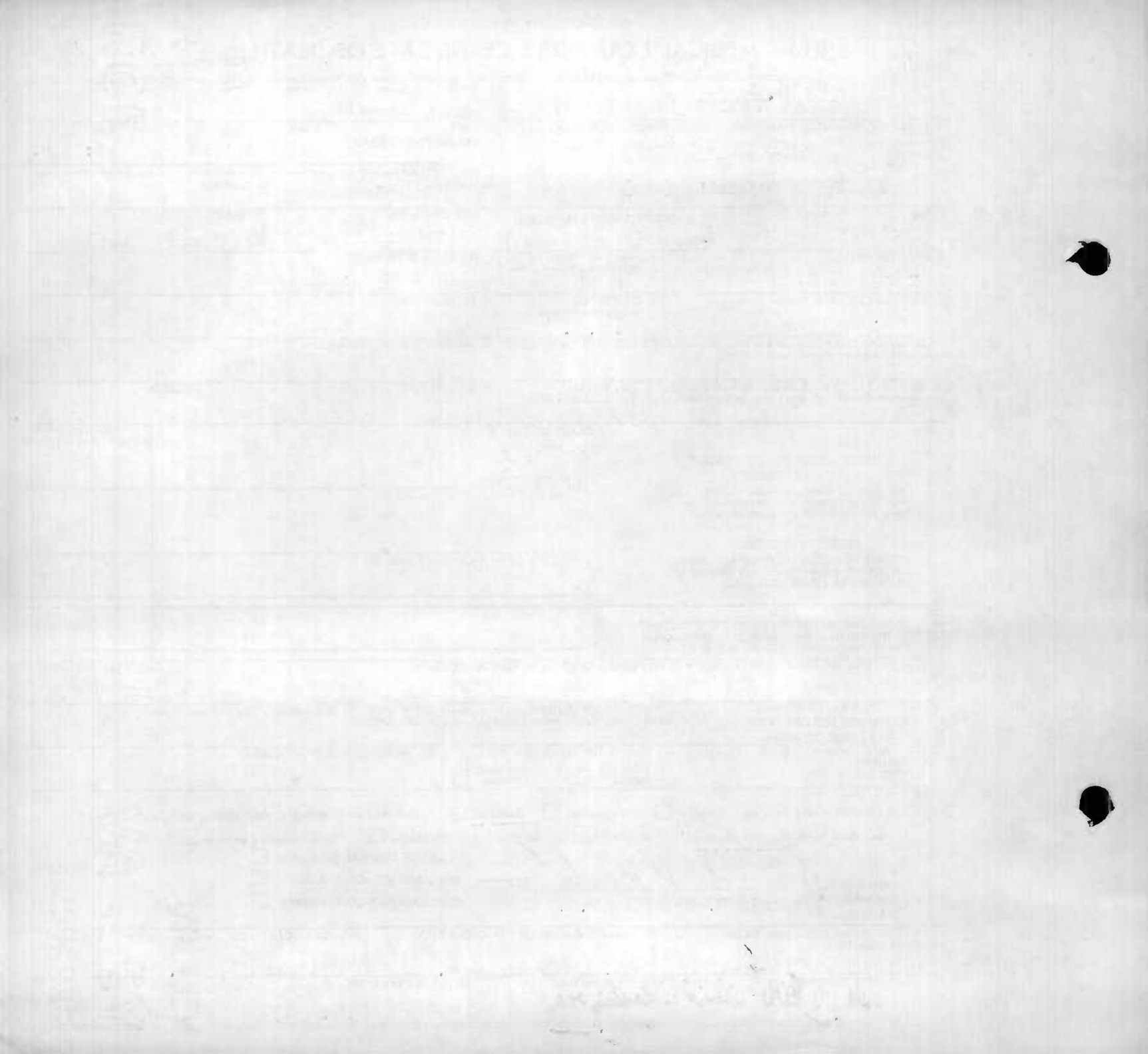
70 5903

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5903

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Delores ELIA LARKINS (Thompson)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PROVIDENT HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 3, 1970 8:32 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negroid</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-2-34</b>		10. AGE (In years lost birthday) <b>36</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Ella Alethea Young</b>		ADDRESS <b>5216 Wilton Hgts. Ave.</b>	
19. <b>345.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Epilepsy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>6/4/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-8-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>James E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>		ADDRESS <b>1348 Calhoun Street</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

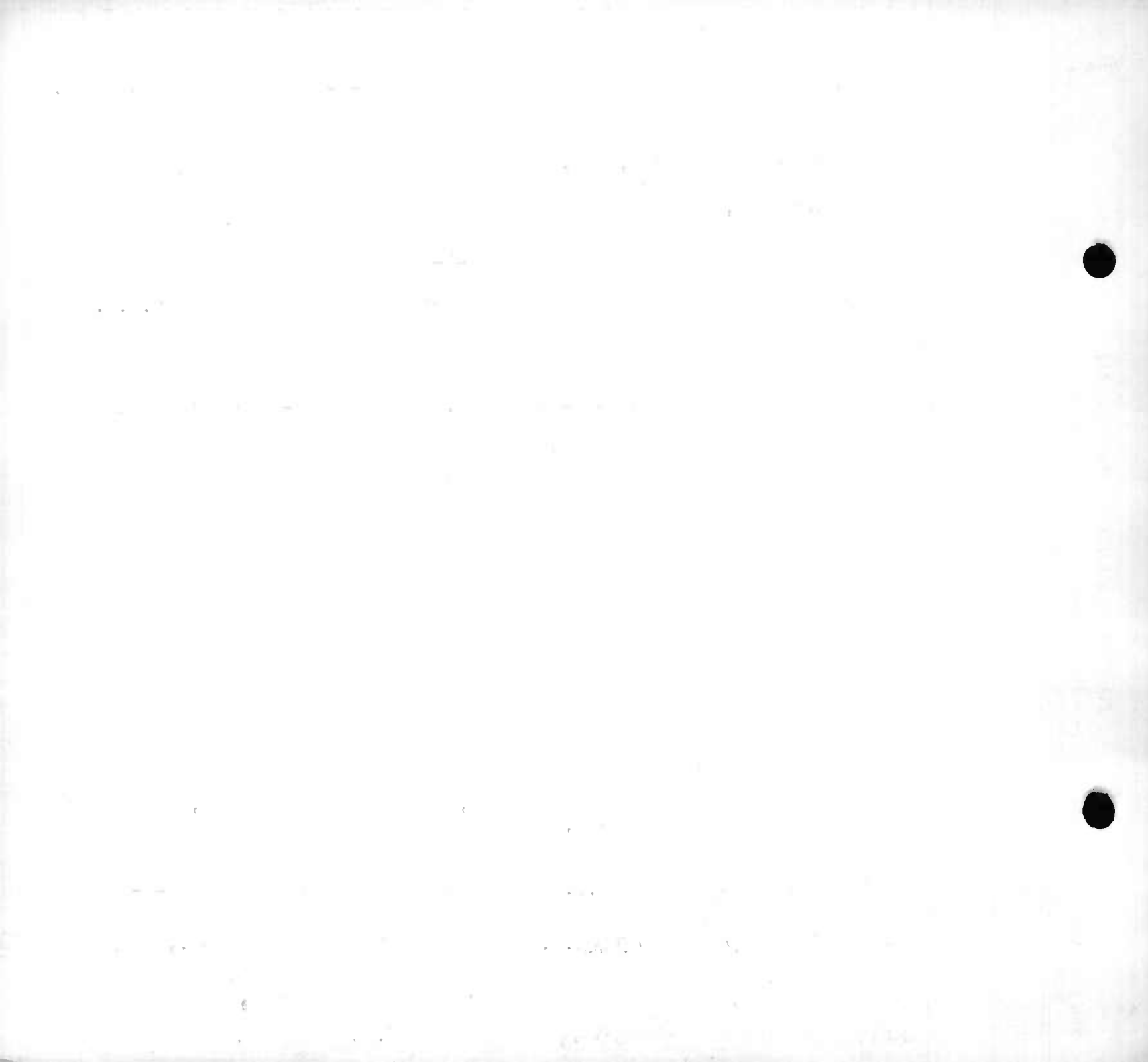
BALTIMORE CITY HEALTH DEPARTMENT				70 5904		REG. NO. 70 5904	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Stewart, Jean</i>		2. DATE AND HOUR OF DEATH <i>6/4/70 3:15 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1548</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Non white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/9/1909</i>	
9. AGE (in years last birthday) <i>61</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>us</i>	
13. FATHER'S NAME <i>William Stewart</i>				14. MOTHER'S MAIDEN NAME <i>Hawkins, Julian</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>		ADDRESS <i>607 Penna Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>25091</i>		CAUSE OF DEATH <i>Arteriosclerotic cardiovascular disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Nephrosclerosis</i>					
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes mellitus</i>					
		(C) <i>Uremia</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>7</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9 MAY</i> 19 <i>69</i> to <i>4 JUNE</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>4 JUNE</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard Tyson, M.D.</i>				23B. DATE SIGNED <i>6-5-70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Dr. Richard Tyson M.D.</i>				23D. ADDRESS <i>936 W. North Avenue Balto. Md. 21217</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-9-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR V. Bailey <i>Kelson F.H. 1348 Calhoun Street</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

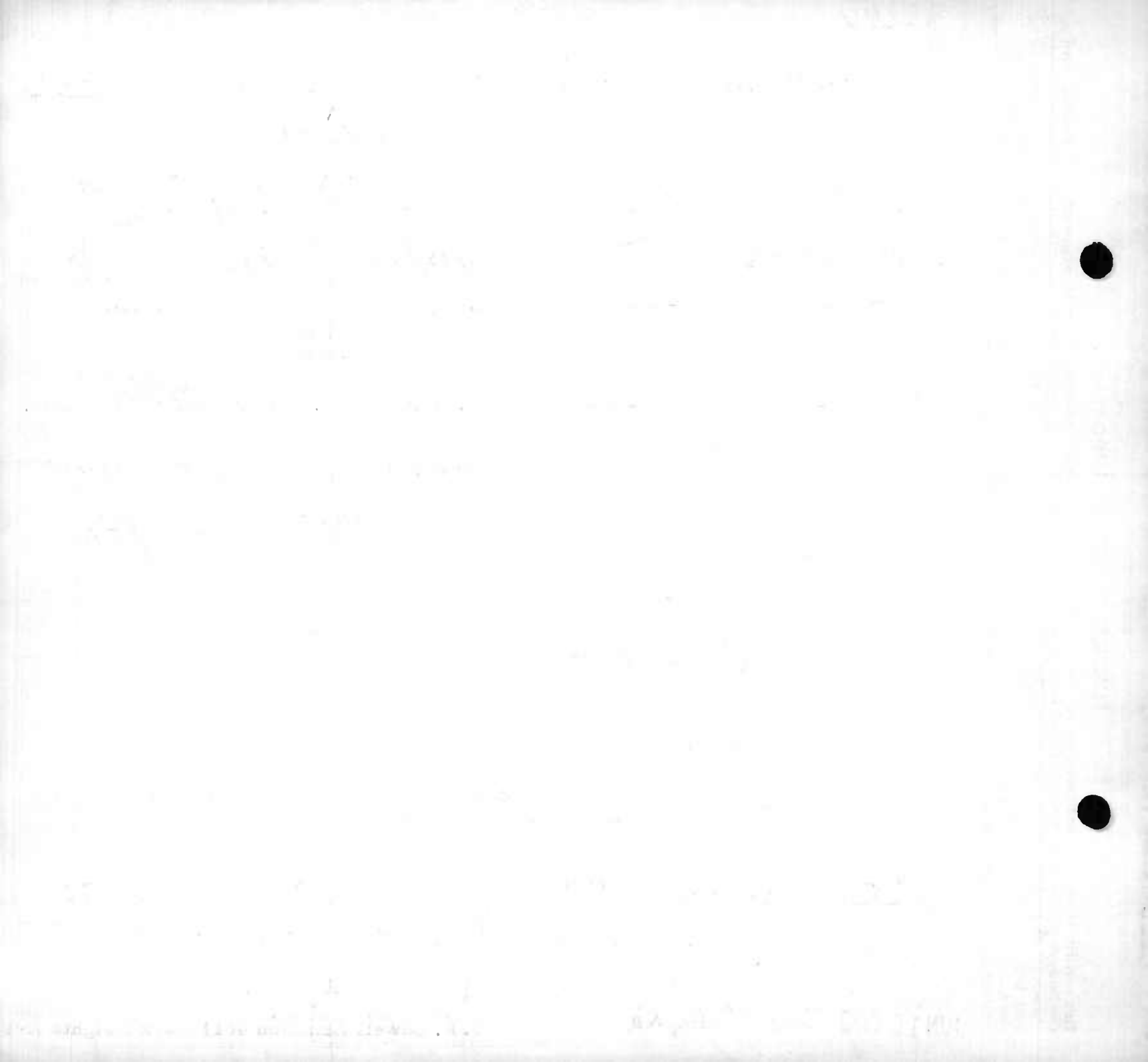
Baltimore City Health Department				70 5905		REG. NO. 70 5905	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lee, Maggie		2. DATE AND HOUR OF DEATH 6-9-70 7:40 a.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 900 Argyle Avenue Apt. 4 B			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-2925D		17. INFORMANT Mrs. Margaret Lee- Daughter		ADDRESS SAME	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ASCVD & CVA & RA Hemiplegia. old CVA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 24, 19 70 to June 9, 19 70 that (I) (we) last saw the deceased alive on June 9, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Elijah Saunders M.D.				23B. DATE SIGNED 6-9-70			
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS M.D.				23D. ADDRESS 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/70		24C. NAME OF CEMETERY OR CREMATORY Western Star Cem.		24D. LOCATION (City, town, or county) (State) Catonville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Violet E. Taylor, R.D.		25C. FUNERAL DIRECTOR Kelson, F.H.		25D. ADDRESS 1348 N. Calhoun St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5906</span>	
BIRTH NO. <span style="font-size: 1.5em;">S-410</span>		70 5906		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MAR GARRET A. SALAFIA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6-6-70 6:45 AM</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <span style="font-size: 1.5em;">42 SINA HOSP</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">1509</span>			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">42 SINA HOSP</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">3030 Oakford Ave</span>			
5. SEX <span style="font-size: 1.2em;">FEM</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/12/88</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">---</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">---</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Salvatore L. Salafia 3030 Oakford Ave.</span>	
18. <span style="font-size: 1.5em;">412.4 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH  (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CARDIAC ARRHYTHMIA</span> DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">LAR DISEASE</span> (B) <span style="font-size: 1.2em;">ATHEROSCLEROTIC CARDIOVASCULAR</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;">DAYS</span>  <span style="font-size: 1.2em;">YEARS</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6-1</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6-6</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6-6</span> 19 <span style="font-size: 1.2em;">70</span> and that (n)(my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span> MD				23B. DATE SIGNED <span style="font-size: 1.2em;">6-6-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">WUBEN DRISANSKI MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">SINA HOSP</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">9 JUN 70</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Parkwood Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 10 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">[Signature]</span> ADDRESS <span style="font-size: 1.2em;">J. E. Howell Lemmon 4611 Park Heights Ave</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5907	
BIRTH NO. 70 5907		CERTIFICATE OF DEATH		30-801992	
1. NAME OF DECEASED (Type or Print) <b>KKK FRED QUINN</b>		2. DATE AND HOUR OF DEATH <b>JUNE 7, 1970 9 30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		8. DATE OF BIRTH <b>09/24/00</b>	
13. FATHER'S NAME <b>GARDNER</b>		14. MOTHER'S MAIDEN NAME <b>ROSE CONQUEST</b>		9. AGE (In years last birthday) <b>69</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-14-8286</b>		17. INFORMANT <b>Alma Adams</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>150X I</b>		CAUSE OF DEATH <b>Herellea Sepsis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Esophagus</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>6 months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 20 1970</b> to <b>June 7 1970</b> and that (I) (we) last saw the deceased alive on <b>June 7 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Bensinger MD</b>		23B. DATE SIGNED <b>JUNE 7, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD BEISINGER, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 2/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pocomoke City</b>	
24D. LOCATION <b>Pocomoke City Md</b>		24E. CITY, TOWN, OR COUNTY <b>Pocomoke City</b>		24F. STATE <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>J. Brooks Ruggold</b>	
25D. ADDRESS <b>1463 N. Carey St</b>					

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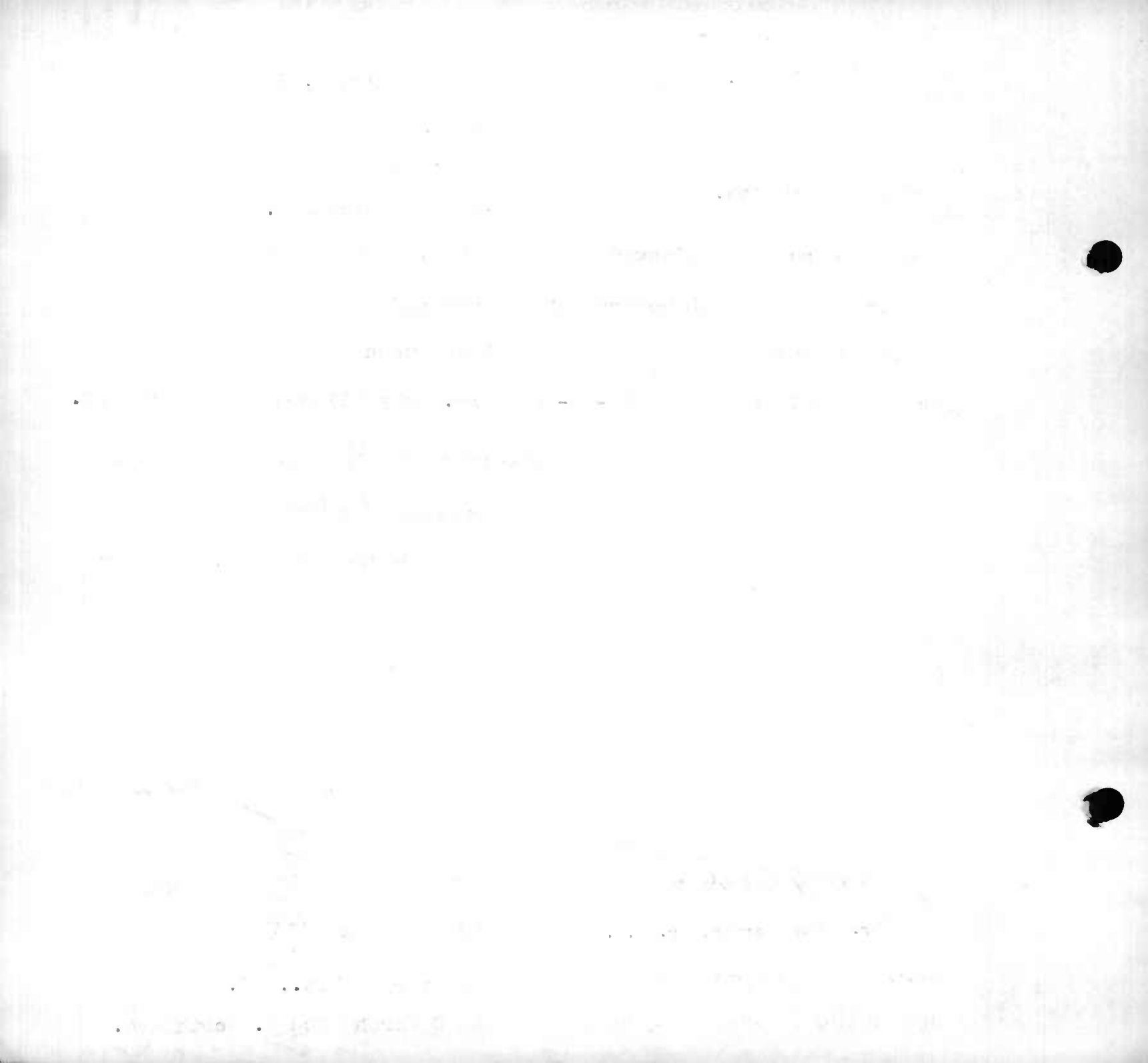
2012/10/20 2012/10/20



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>Q-500</b> M.E. CASE NO. <b>70 5908</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>70 5908</b>	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM E. QUEEN</b>			2. DATE AND HOUR OF DEATH <b>June 9, 1970</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2620 Shirley Ave.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1513</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2620 Shirley Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov 1, 1888</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>US Government</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Sylvester Queen</b>			14. MOTHER'S MAIDEN NAME <b>Emma Queen</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>218-03-9541</b>		17. INFORMANT ADDRESS <b>Mrs. Ruby Filmore 1902 Payson St.</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis &amp; Prostate - 1 year</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Wide spread metastasis</b> <b>Schistosomiasis Cardiac</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1969</b> to <b>9 June 1970</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4 June 1970</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Simon Carter, Jr.</b>				23B. DATE SIGNED <b>9 June 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Simon Carter, Jr. M.D.</b>			23D. ADDRESS <b>445 Park Heights Ave.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/12/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cemetery Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970 Robert E. Fisher, M.D.</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C March 928 E. North Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

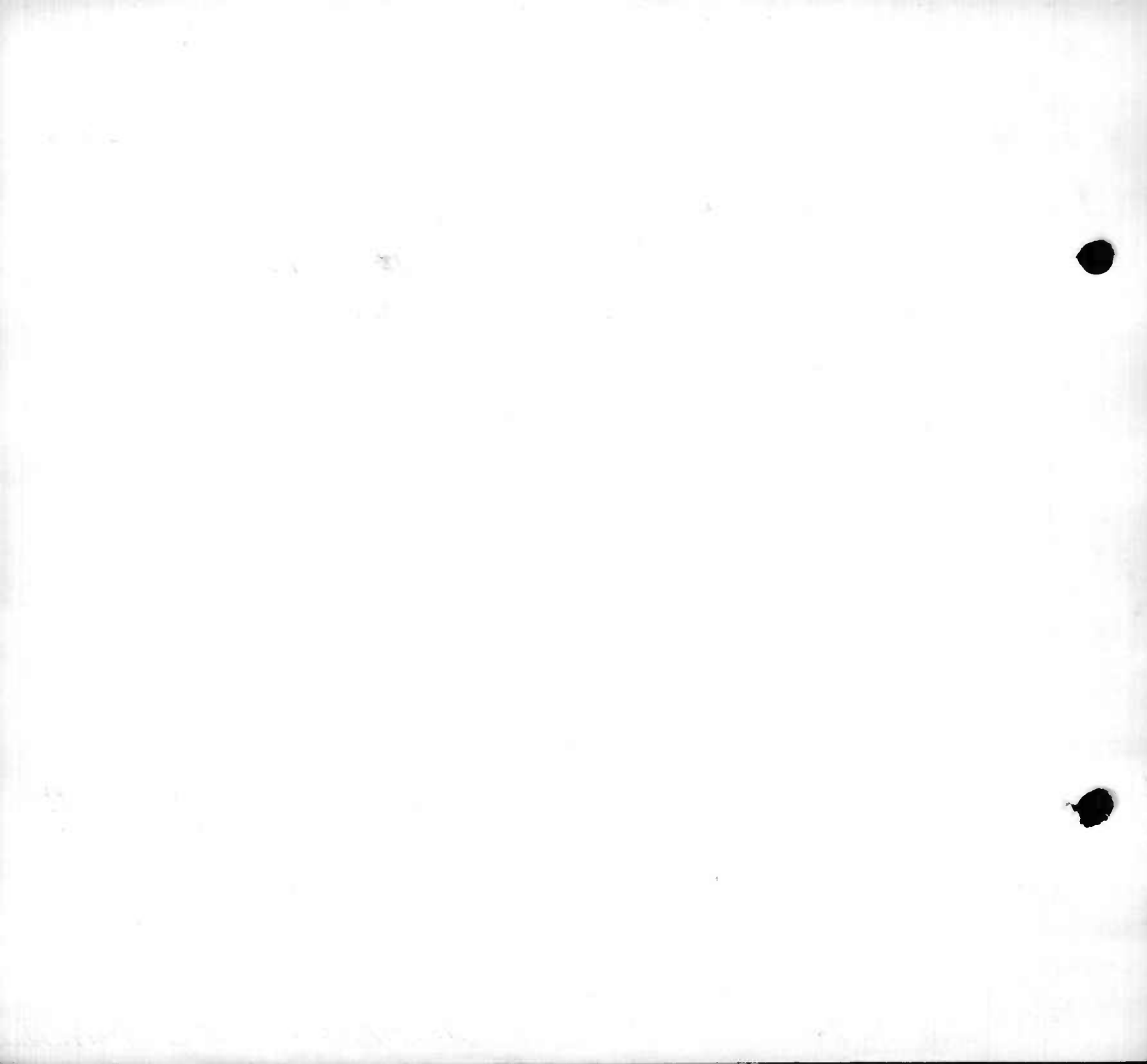
BIRTH NO. 1-625				70 5909		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5909	
1. NAME OF DECEASED (Type or Print) <b>PEARSON, Mary Catherine</b>						2. DATE AND HOUR OF DEATH <b>June 6, 1970 9:30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>70 Bolton Hill Nursing &amp; Convalescent Ctr.</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2516 Barkley Street 21218</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-18-98</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Morris</b>						14. MOTHER'S MAIDEN NAME <b>Anna Boston</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-24-0084</b>		17. INFORMANT ADDRESS			
18. <b>412.3 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF</b> <b>(B) Anterolateral myocardial infarction</b> <b>(C) Paget's disease</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b> <b>years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>5/22 1970</b> to <b>6/6 1970</b> , that (I) (we) last saw the deceased alive on <b>6/6 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>ae MARCH</b>						23B. DATE SIGNED <b>6/8/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MARCH MD</b>		23D. ADDRESS <b>2 E Paul St Balt MD 21202</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/10/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arboretum Mem PK</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>J. M. C. March</b>		ADDRESS <b>928 E North</b>			

Barclay st

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5910</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">B-653</span> <span style="font-size: 1.5em;">70 5910</span> <span style="font-size: 1.5em;">70 5910</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LEROY MACDONALD BARNEY BARNETT</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 8, 1970 5<sup>00</sup> P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">44 Union Memorial Hospital</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <span style="font-size: 1.2em;">304 E 20th St</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12-08-18</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">51</span>	10. Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Dish Washer</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">JAMES MOSE BARNEY</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Rachel Ann Jackson</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-30-2968</span>		
			17. INFORMANT <span style="font-size: 1.2em;">CHART</span>		
18. CAUSE OF DEATH <span style="font-size: 1.2em;">303.21</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CHRONIC ALCOHOLISM, CVA?</span> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6/6</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6/8</span> 19 <span style="font-size: 1.2em;">70</span> and that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6/8</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">HARVEY B. SWERDLOW</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">6/8/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Harvey B. Swerdlow</span>				23D. ADDRESS <span style="font-size: 1.2em;">UMH</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">6/12/70</span>		<span style="font-size: 1.2em;">Arbutus Mem Park</span>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
<span style="font-size: 1.2em;">Baltimore, Md.</span>		<span style="font-size: 1.2em;">Wm. MARRAS 928 E. North Ave</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
<span style="font-size: 1.2em;">JUN 10 1970</span>		<span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<span style="font-size: 1.2em;">928 E. North Ave</span>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 5911				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5911	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
GREEN, ABRAHAM				June 2nd, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				501 E. 23RD. STREET			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Hr. Min.
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-25-15	53			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
UNEMPLOYED				VIRGINIA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN Walter Green				UNKNOWN Mary Gardner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-034581		MARY WHITE		426 E. 22ND. STREET	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				RESPIRATORY ARREST			
DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) CVA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from MAY 20th 1970 to JUNE 2nd 1970 that (I) (we) last saw the deceased alive on JUNE 2nd 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Cabrera M.D.				June 2nd 1970			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JUAN CABRERA MD				UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/6/70				TAPHANNA VA	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 10 1970		Jabab E. Jabab, R.D.		WM C MARCH		928 E. North Ave	

1000 1000 1000

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G-420 70 5912 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 5912

1. NAME OF DECEASED (Type or Print) RONALD GILES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 407 E. 21½ St.		3. DATE PRONOUNCED DEAD Month Day Year 6 7 1970 Hour 4:40 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. CITY OR TOWN Balto.	
10. AGE (In years lost birthday) 34		11. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. DATE OF BIRTH 10/17/36		13. STREET AND NUMBER 409 E. 21½ St.	
14. BIRTHPLACE (State or foreign country) MARYLAND		15. CITIZEN OF WHAT COUNTRY? HARRY SPRIGGS	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		17. KIND OF BUSINESS OR INDUSTRY SAKARH GILES	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		19. SOCIAL SECURITY NO. 214-54-5803	
20. INFORMANT MARY JOHNSON		21. ADDRESS 430 E 21st St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-7-70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/10/70	
24C. NAME OF CEMETERY or CREMATORY Mt AUBURN CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Chas E. Fisher, M.D.	
25C. FUNERAL DIRECTOR WM MARCIA		25D. ADDRESS 928 E NORTH AVE	

Letter from M.E.'s office

8-20-70

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5913</span>	
T-425 70 5913				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SARAH Tilghman</b>		2. DATE AND HOUR OF DEATH <b>6-6-70 7 4 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1513</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Midtown Home Inc.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER <b>2661 Park Heights Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-04</b>	9. AGE (In years lost birthday) <b>66</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Acme Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>John Gillis</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Tilghman</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-92-6373A</b>		17. INFORMANT <b>Patrick Brown</b>	
				ADDRESS <b>2661 Park Heights Terrace</b>	
18. <b>180X + 1250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Respiratory Failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ca of Cardio spread to Kidney</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Abdominal Distention</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>			
(C) <b>Diabetes Mellitus</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-22 1970</b> to <b>6-6 1970</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in <b>(10) (20)</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Willard Appleford</b>				23B. DATE SIGNED <b>6-6-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Willard Appleford</b>		23D. ADDRESS <b>6615 Reisterstown Rd.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/10/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Anne Arundel County</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>	
				ADDRESS <b>3035 W. North Avenue</b>	

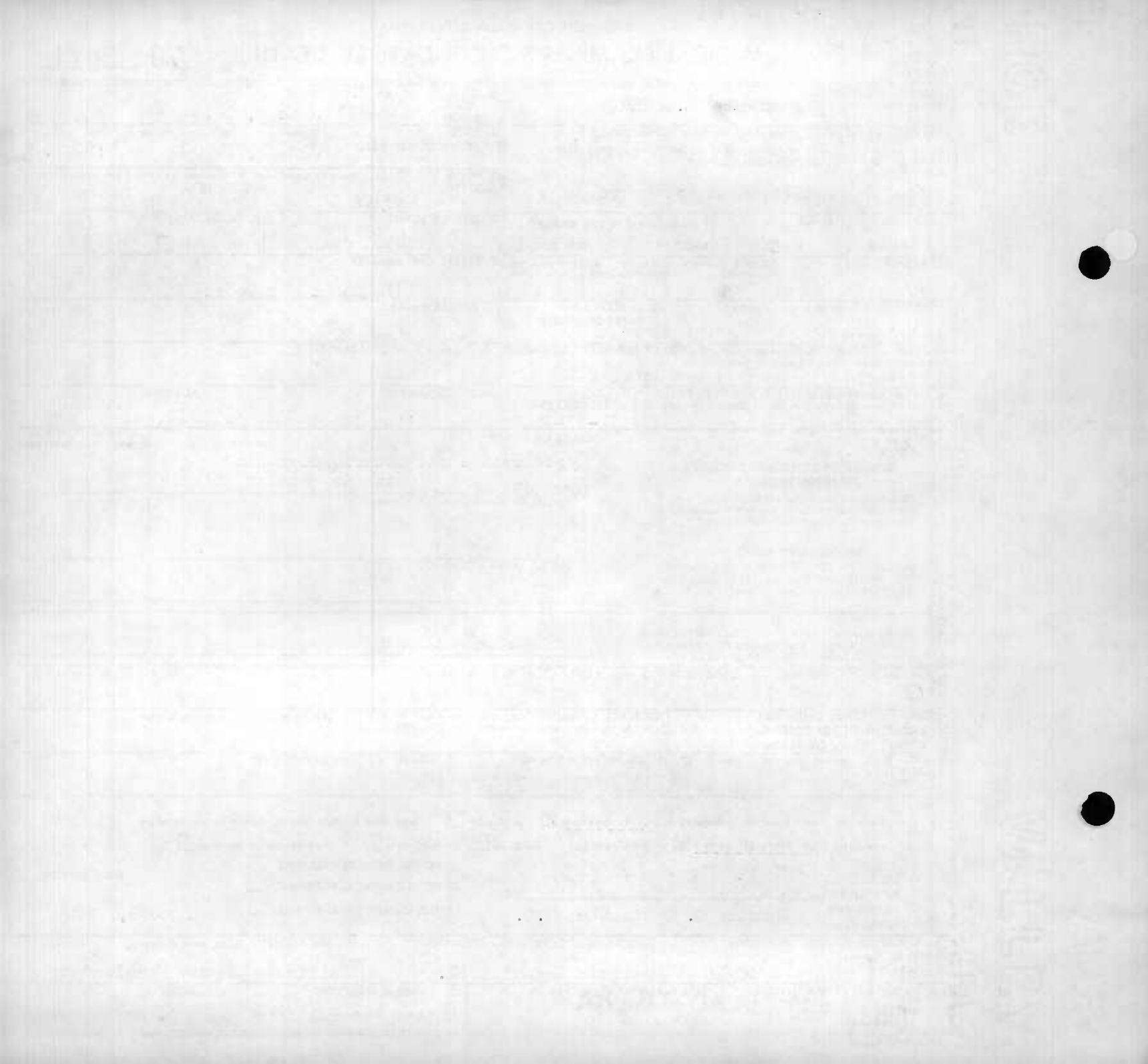
Park Heights Terr.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5914

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILDRED L. BERRY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 8, 1970		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 1678 Mount Mor Court		3. DATE PRONOUNCED DEAD Month Day Year June 8, 1970		Hour 2:25 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 1501			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/25/14		10. AGE (in years last birthday) 56		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 1678 Mount Mor Court	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafateria		14B. KIND OF BUSINESS OR INDUSTRY School System		13. FATHER'S NAME George Lee	
15. MOTHER'S MAIDEN NAME Mary Osborne		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 216-05-1540		18. INFORMANT Mona Smith 1450 Mountmore Court			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.24 250.9 Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus					
20A. DATE OF OPERATION O		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 9, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/70		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore County Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Avenue			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 5915

1. NAME OF DECEASED (Type or Print) <b>CHARLES LAWSON</b>		2. DATE AND HOUR OF DEATH <b>2:45 PM. 6/5/70</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Ave, Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3911 Mondawmin Ave 21216 007</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-05</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	9. AGE (in years last birthday) <b>64</b>
13. FATHER'S NAME <b>Richard Lawson</b>		11. BIRTHPLACE (State or foreign country) <b>Jamacia B. W;</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>212-12-2034</b>		14. MOTHER'S MAIDEN NAME <b>Jane Drummond</b>	
17. INFORMANT <b>Mrs. Mamie Lawson</b>		ADDRESS <b>3911 Mondawmin Avenue BCH Records: Baltimore, Md. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>188X I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARCINOMA OF BLADDER</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic to Spine + Brain</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-6-70</b> 19 to <b>6-5</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>6-5</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Arnold Lewinson M.D.</b>		23B. DATE SIGNED <b>6-5-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Arnold Lewinson M.D.</b>		23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/11/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Hays</b>	
25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		ADDRESS <b>3035 W. North Avenue</b>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>B-623</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 5916</b>	
1. NAME OF DECEASED (Type or Print) <b>BRAXTON Leona</b>			2. DATE AND HOUR OF DEATH <b>6/6/70</b> <b>3</b> <b>A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>George Washington Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY		
5. SEX <b>Female</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-16-08</b>		9. AGE (In years last birthday) <b>61</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Columbia S.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Paul McCray</b>			14. MOTHER'S MAIDEN NAME <b>Sophia Wilson</b>		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>218-42-3851</b>		17. INFORMANT <b>MRS. LOUISE MOORE</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic hepatitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Congestive Heart Failure</b> <b>Generalized Arteriosclerosis</b> <b>Diabetes Mellitus</b>			19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b> <b>year</b>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>30 APRIL 1969</b> to <b>5 JUNE 1970</b> that (1) (we) last saw the deceased alive on <b>5 JUNE 1970</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Tyson, M.D.</b>				23B. DATE SIGNED <b>6-6-70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>936 W. NORTH AVE. BALTO 21217 Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>BURIAL</b>		<b>6-11-70</b>		<b>Mt. Auburn Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JUN 10 1970</b>		<b>Robert E. Taylor, Md.</b>		<b>He Mueller</b>	
				ADDRESS <b>3035 W. North Ave</b>	

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Mr. J. H. Mearns  
New York, N.Y.

Bureau of the  
U.S. Army

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
B-653 70 5917									
CERTIFICATE OF DEATH									
REG. NO. 70 5917									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BARNETT, John E.</b>				2. DATE AND HOUR OF DEATH <b>6-4-70 2:45 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1510</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital, Baltimore, Md.</b>						C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4117 CHATHAM Rd.</b>									
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/13/93</b>	9. AGE (in years last birthday) <b>77</b>	10. Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Abendeen Proving Ground Baltimore Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>William Barnett</b>				14. MOTHER'S MAIDEN NAME <b>Emily Ringold</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>				16. SOCIAL SECURITY NO. <b>216-07-8173</b>		17. INFORMANT <b>Mrs. Mattie L. Barnett 4117 Chatham Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				(A) IMMEDIATE CAUSE <b>PERITONITIS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>NECROSIS AND DISRUPTION OF GASTROJETUNOSTOMY ANASTOMOSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>GASTRECTOMY AND GASTROJETUNOSTOMY</b>				<b>1 1/2 days.</b>	
(C) FOR BLEEDING GASTRIC ULCER				<b>4 2 days.</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b>									
19A. DATE OF OPERATION <b>6-2-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Upper GI-bleeding</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>5-31-1970</b> to <b>6-4-1970</b> that <del>he</del> (we) last saw the deceased alive on <b>6-4-1970</b> and that (n) (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Benjamin R. Chipman, MD</b>						23B. DATE SIGNED <b>6-4-70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Benjamin R. Chipman, MD</b>						23D. ADDRESS <b>3640 FORDS LANE, BALTIMORE, Md. 21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/10/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		ADDRESS <b>3035 W. North Avenue</b>			

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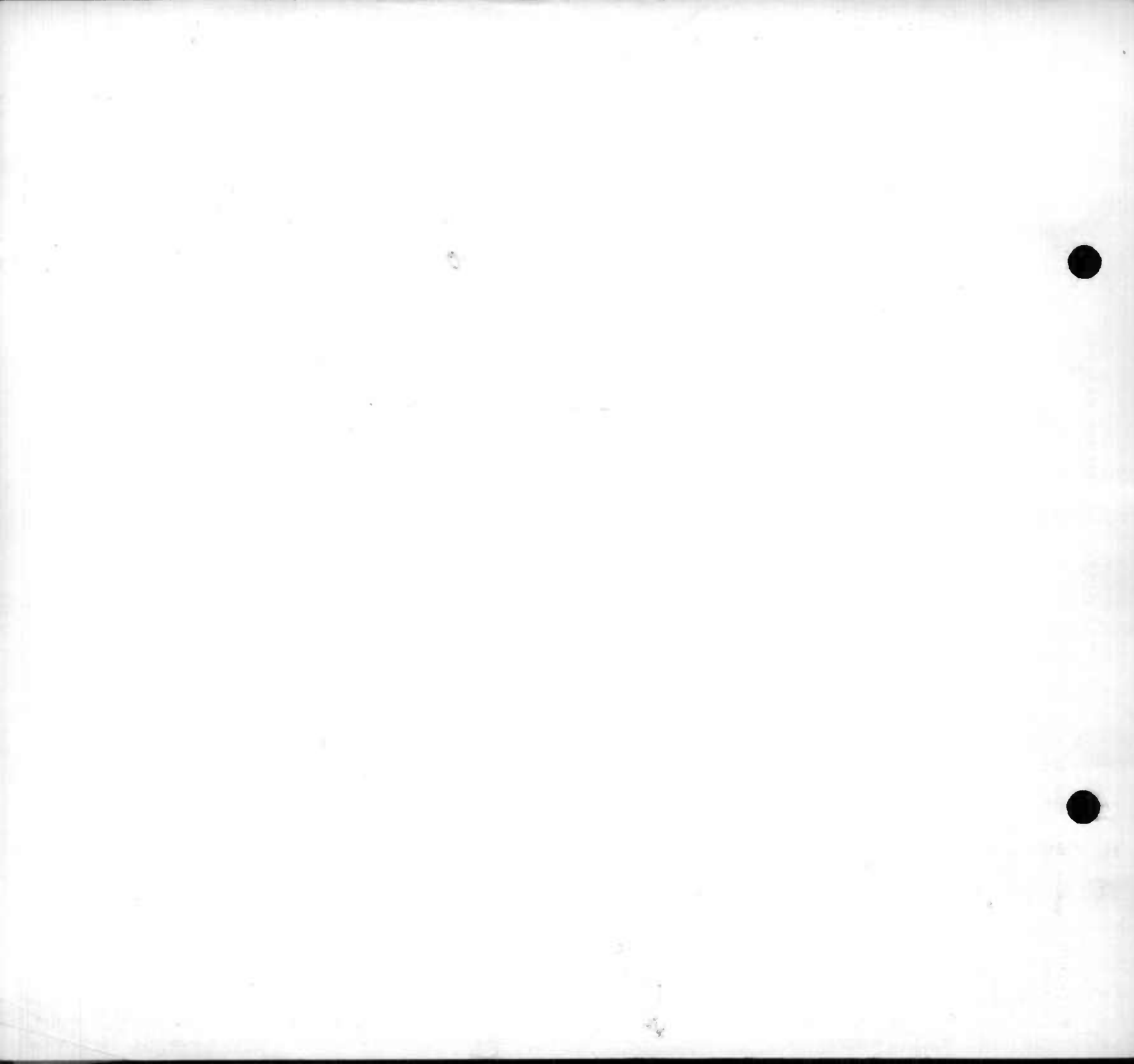
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James H. Thompson  
James H. Thompson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

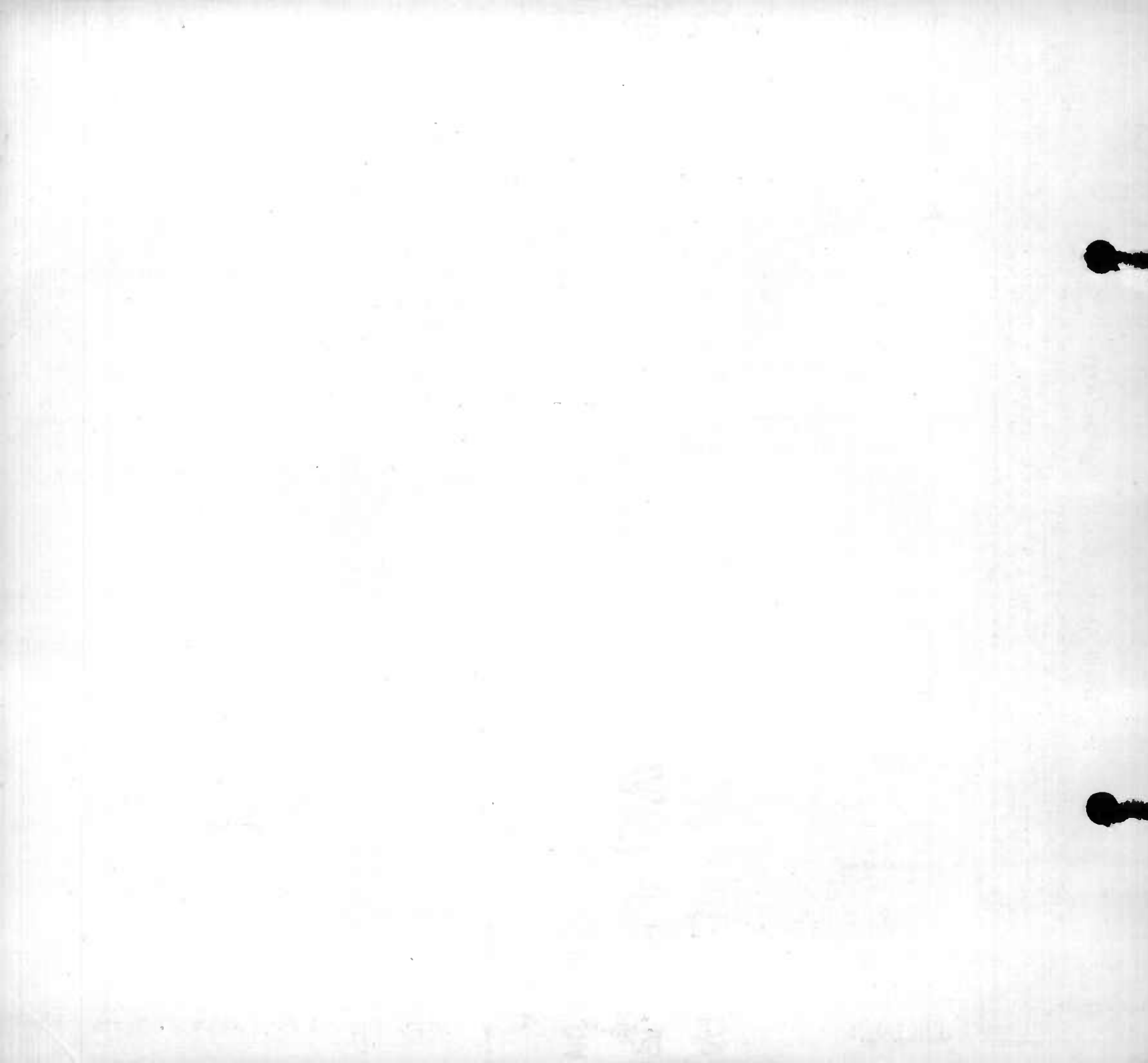
<div style="display: flex; justify-content: space-between;"> <span>G-635</span> <span>70 5918</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>70 5918</span> </div>			
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>MARY E. GORDON</u>		2. DATE AND HOUR OF DEATH <u>6/4/70</u> <u>10:30</u> <u>P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY _____ C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1116 CHERRYHILL RD APT. F</u>	
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/32</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF EDUCATION</u>	
11. BIRTHPLACE (State or foreign country) <u>SO. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD RAGIN</u>		14. MOTHER'S MAIDEN NAME <u>NANCY RICHARDSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-1062</u>	
17. INFORMANT <u>SELF</u>		ADDRESS <u>Mr. Edward Ragin 2843 Round Road</u>	
18. <u>154.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of the Rectum</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>2 metastases to Liver, ovary.</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) _____</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>JUNE 3</u> 19 <u>70</u> to <u>JUNE 4</u> 19 <u>70</u> that <u>(1)</u> (we) last saw the deceased alive on <u>JUNE 4</u> 19 <u>70</u> and that <u>(1)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>William Eric John, M.D.</u>		23B. DATE SIGNED <u>6/4/70</u>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS <u>South Balto Gen Hospital.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/8/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1970</u>		25B. NAME OF FUNERAL HOME <u>Nutter Funeral Home</u>	
25C. FUNERAL DIRECTOR _____		ADDRESS <u>3035 W. North Avenue</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
W-452 70 5919		70 5919		70 5919	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, MYRTLE</b>			2. DATE AND HOUR OF DEATH <b>6/4/70 3:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MD.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1608</b>		
5. SEX <b>F</b>			6. RACE <b>N.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Vernon Scott</b>			14. MOTHER'S MAIDEN NAME <b>Mabel Mathews</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-20-6690</b>		17. INFORMANT ADDRESS <b>Mr. Clarence Williams 1019 Wildwood Pky</b>
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused the death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>INTRACRANIAL HAEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>ASCVD.</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>6-1</b> 19 <b>70</b> to <b>6-4</b> 19 <b>70</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6-4</b> 19 <b>70</b> and that (in my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rajinder P. Gandhi</b>				23B. DATE SIGNED <b>6/4/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAJINDER P. GANDHI</b>				23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE MD. 21216</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/8/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR ADDRESS <b>Nutter Funeral Home 3035 W. North Avenue</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.S.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Nutter Funeral Home 3035 W. North Avenue</b>	

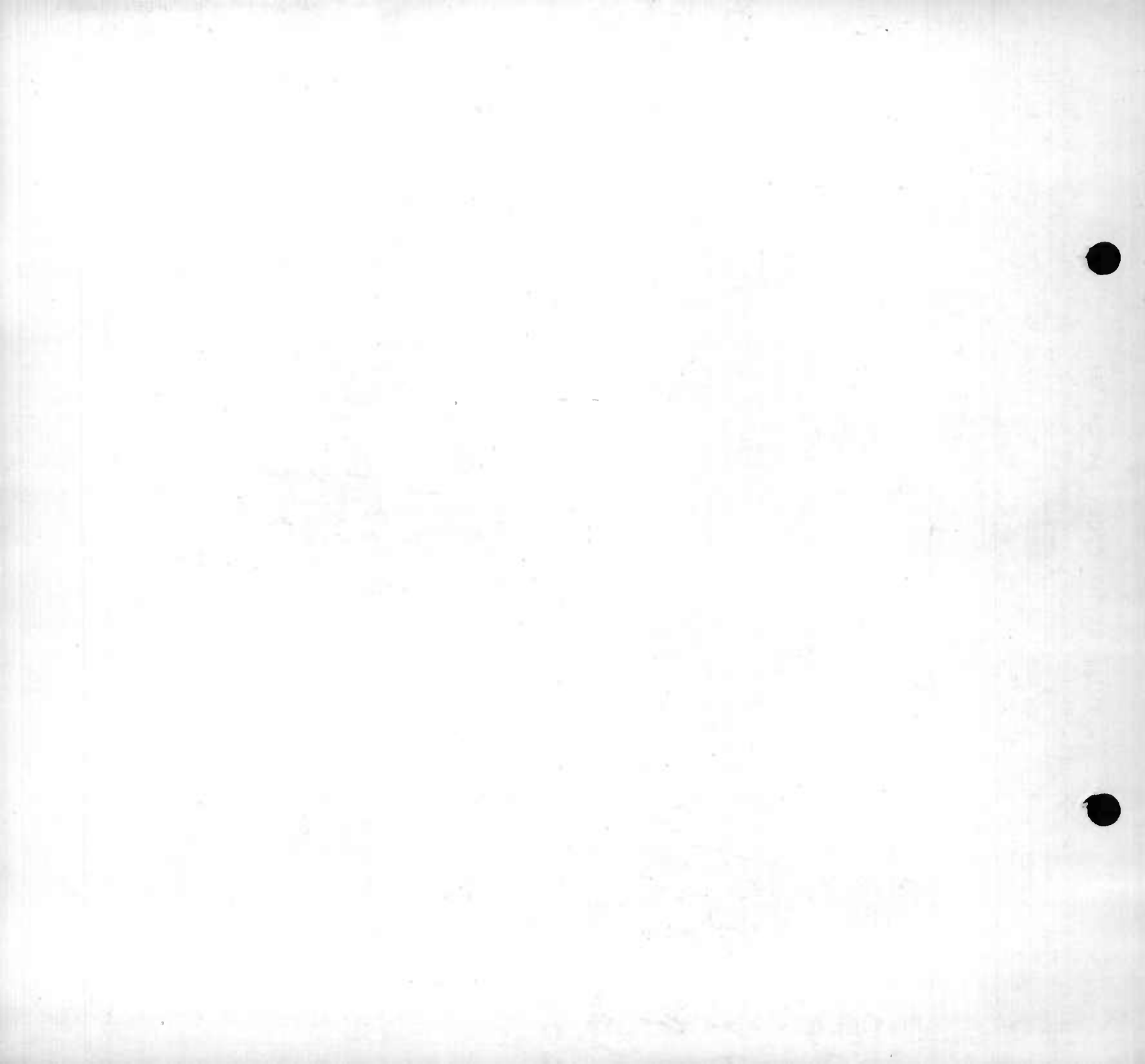




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

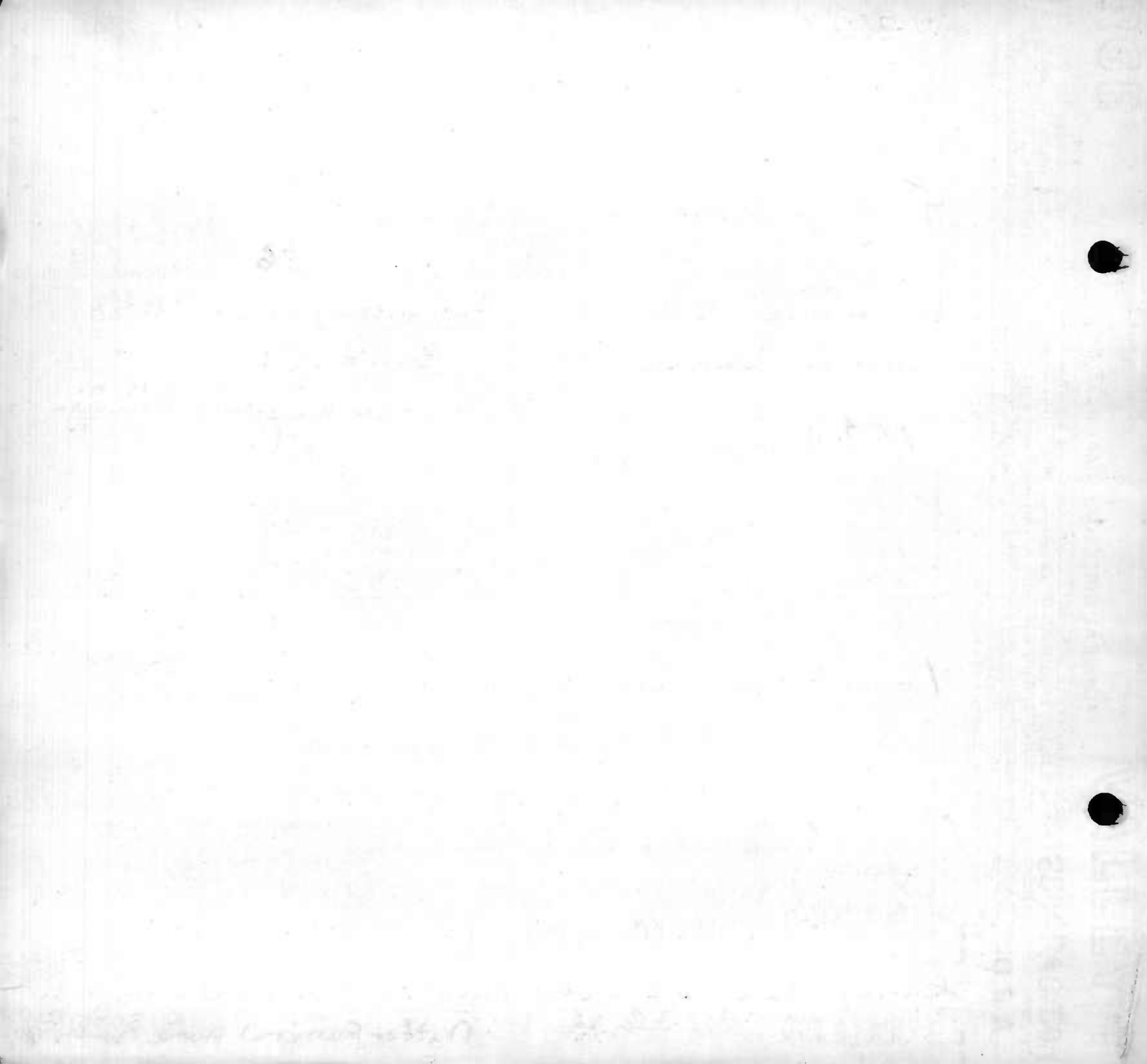
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5920</span>	
BIRTH NO. <span style="font-size: 1.5em;">B-250</span>				70 5920 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">William Samuel Bacon</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 2, 1970</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Saint Agnes Hospital</span>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Howard</span> <span style="float: right; font-size: 1.5em;">6300</span>		
5. SEX <span style="font-size: 1.2em;">Male</span> 6. RACE <span style="font-size: 1.2em;">Negro</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <span style="font-size: 1.2em;">5/5/1919</span> 9. AGE (In years last birthday) <span style="font-size: 1.2em;">51</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mechanic</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Truck Company</span>		
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Walter Bacon</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Florence Ebb</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WWII</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-12-1025</span>		
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Catherine Bacon</span>			ADDRESS <span style="font-size: 1.2em;">3621 Mt Olive Drive</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">412.1 I</span>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Coronary artery Disease with Hypertension and Atherosclerosis; Cerebral artery Disease</span>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">arteriosclerosis</span>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1944-1970</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4-3-70</span> 19 to <span style="font-size: 1.2em;">4-8-70</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-8-70</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Robert B. Taylor MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">6-4-70</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert B. Taylor MD</span>			23D. ADDRESS <span style="font-size: 1.2em;">700 Cathedral</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			24B. DATE <span style="font-size: 1.2em;">6/5/70</span>		
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National Cemetery</span>			24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 10 1970</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor JR</span>		
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Nutter Funeral Home</span>			ADDRESS <span style="font-size: 1.2em;">3035 W. North Avenue</span>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 5921</span>	
<b>W-362 70 5921</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>CATHERINE WEATHERS</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>11:58 PM on 6-4-70.</i>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <i>46 LUTHERAN Hospital</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1607</i> <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>E. STREET AND NUMBER</b> <i>3016 Mosher ST.</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. RACE</b> <i>Negro</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>10-12-33</i>		<b>9. AGE</b> (In years lost birthdate) <i>86</i>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>House wife</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Georgetown S. C.</i>	
<b>13. FATHER'S NAME</b> <i>Charles Lance</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Binkus?</i>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <i>George Weathers</i>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <i>Renal failure</i> <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac failure</i> <b>(C)</b> <i>Carcinomatosis.</i>			
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <i>6-2-70</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>Gastric Ulceration - Carcinoma</i>		<b>20A. AUTOPSY?</b> (Yes or No) <i>NO</i>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <i>5-23-70</i> to <i>6-4-1970</i>, that (I) (we) last saw the deceased alive on <i>6-4-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>[Signature]</i>				<b>23B. DATE SIGNED</b> <i>6-5-70</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>Y. BABURAO MD</i>		<b>23D. ADDRESS</b> <i>LUTHERAN HOSPITAL</i>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>June 9, 1970</i>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Arboretus mem. Bk. - Baltimore County Md.</i>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JUN 10 1970</i>		<b>25B. NAME OF REGISTRAR</b> <i>John E. Taylor MD</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Nutter Funeral Home</i>	
<b>25D. ADDRESS</b> <i>3035 W. North Ave</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5922</span>	
S-452 70 5922		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HELEN Sliwinski</u>		2. DATE AND HOUR OF DEATH <u>6-9-70</u> <u>4 45</u> PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>203</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BOLTON HILL NURSING &amp; CONVALESCENT CENTER</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>841 BOND STREET</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/86</u>	9. AGE (In years last birthday) <u>84 yrs</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
13. FATHER'S NAME <u>WALTER Sliwinski</u>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-9137</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary heart disease</u> (B) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>generalized arteriosclerosis</u> <u>osteoporosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/1/71</u> 19 <u>70</u> to <u>6/9</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>6/10/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>		23D. ADDRESS <u>2 E Pearl St Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-12-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE County, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Ziegler Inc. 1901-07 EASTERIN AVE</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 5923	
Z-453 70 5923		REG. NO. 70 5923	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
HELEN R. ZIELINSKI		June 9, 1970 6:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL BALTIMORE, MD.		A. STATE MARYLAND	
		B. COUNTY 1652	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4915 SINCLAIR LANE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-91
9. AGE (In years last birthday) 78		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME GEORGE ROGINSKI		14. MOTHER'S MAIDEN NAME MARTHA ROGINSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-16-9398	
17. INFORMANT Daughter		ADDRESS	
18. CAUSE OF DEATH 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (this hospital) attended the deceased from 6-7-1970 to 6-9-1970 that (we) last saw the deceased alive on 6-9-1970 and that in (our) opinion death occurred on the date and hour end from the causes stated above. (We) (did) (not) view the body after death. 23A. SIGNATURE Rolando A. Mendoza, MD 23B. DATE SIGNED 6/9/70 23C. PHYSICIAN'S NAME (Type) ROLANDO A. MENDOZA, MD 23D. ADDRESS 100 N. Broadway St. 21231 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 6-11-1970 24C. NAME of CEMETERY or CREMATORY Holy Rosary 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland 25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970 25B. NAME OF REGISTRAR Robert E. Zeller, MD 25C. FUNERAL DIRECTOR Lilly & Zeller Inc. 25D. ADDRESS 1901-07 Eastern Ave.			

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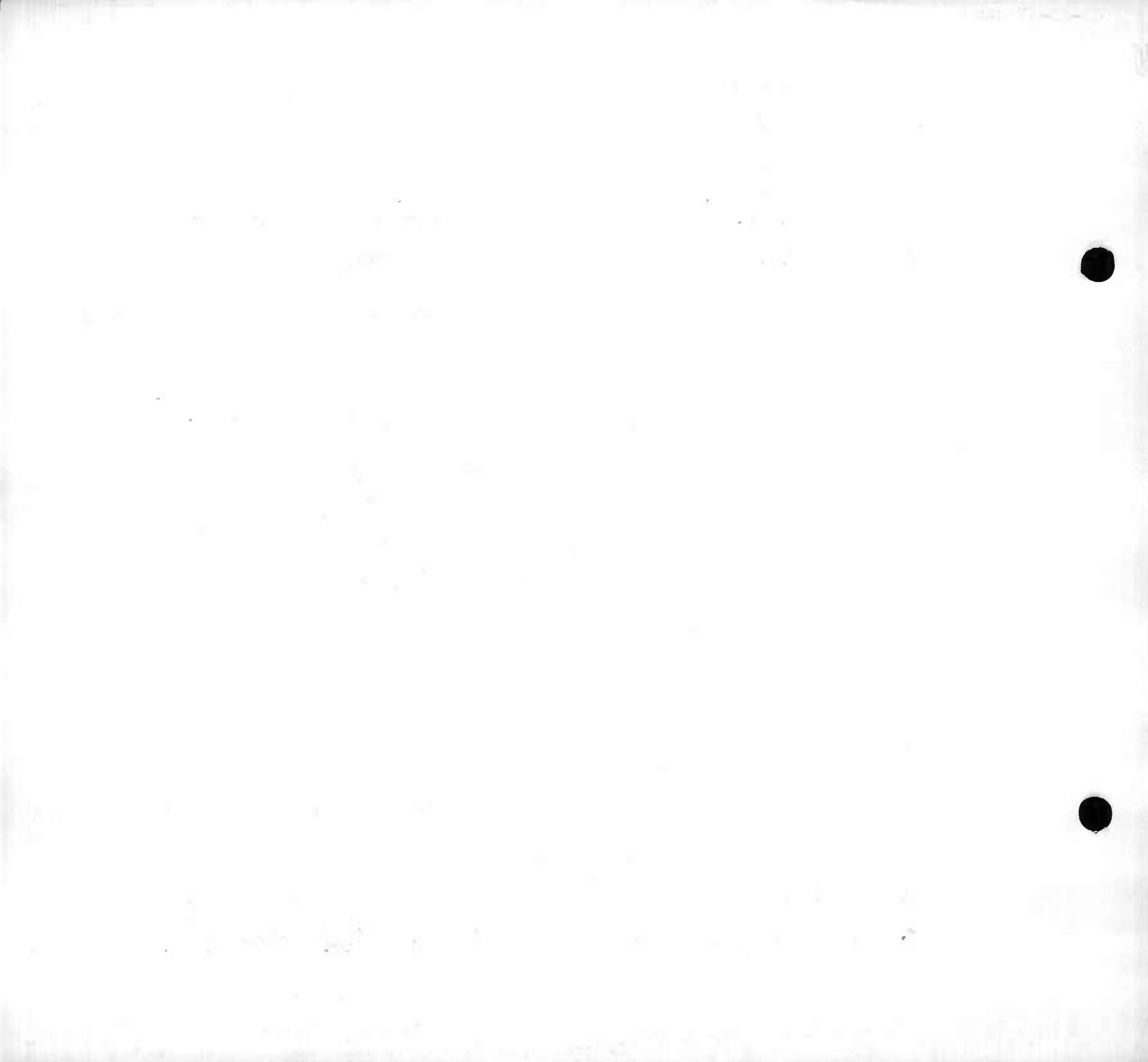
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

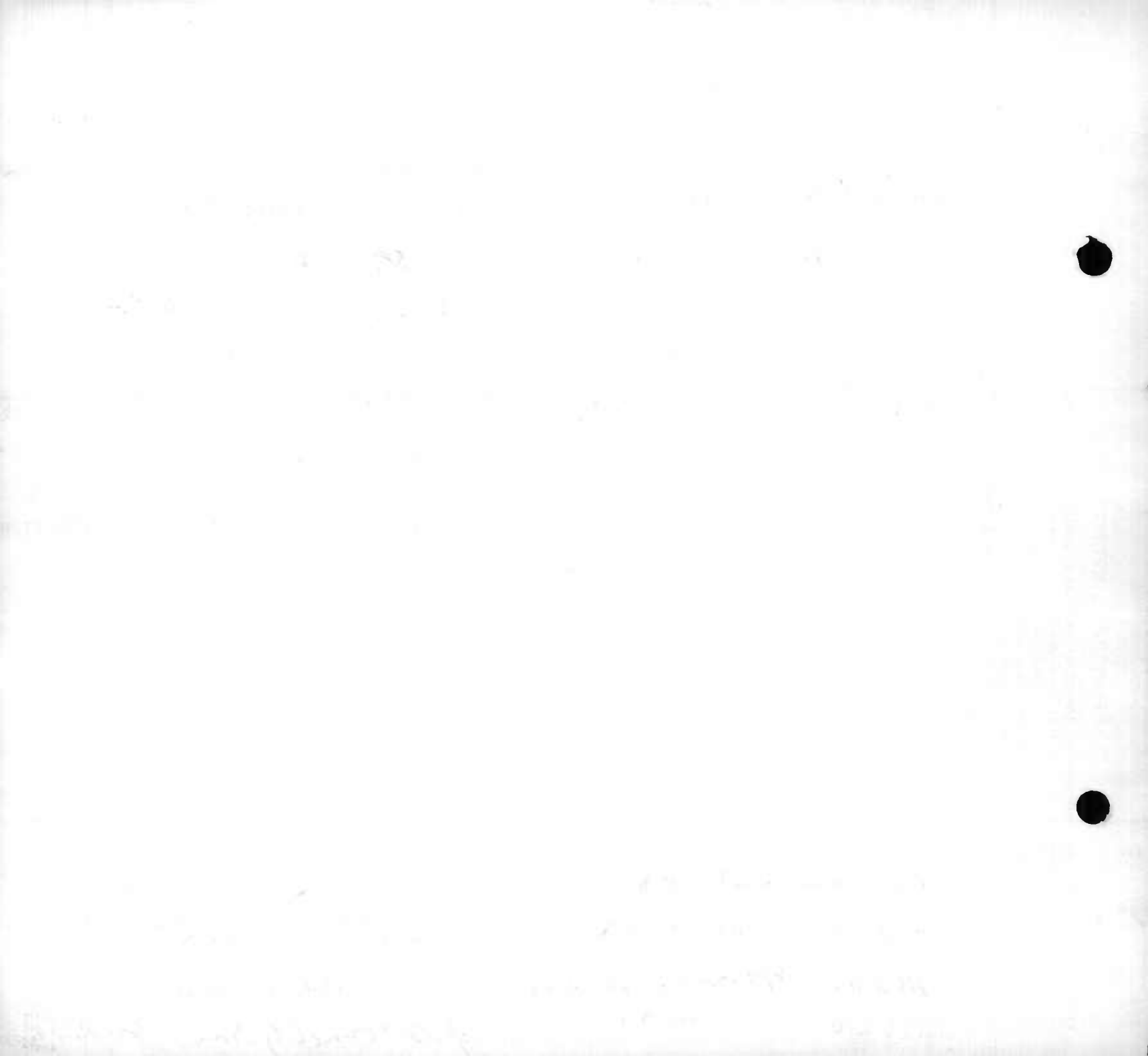
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5924	
BIRTH NO. 70 5924		CERTIFICATE OF DEATH		REG. NO. 70 5924	
1. NAME OF DECEASED (Type or Print) WOMACK, SARAH		2. DATE AND HOUR OF DEATH 6-9-70 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Balt. City Hospital FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave, Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 1402 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 553, Mosku St. 21223			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907 05	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-24-505		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. 713.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Quadriplegia - 2% Cervical spondylosis (B) Extensive degenerative (C) CBS - U.T.T.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 11-16-1969 to 6-9-1970 that (I) (we) last saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE R. V. VENKATE SAN MD. 23B. DATE SIGNED 6-9-70.	
23C. PHYSICIAN'S NAME (Type) R. V. VENKATE SAN MD.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 6/14/70		24C. NAME OF CEMETERY OR CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5925	
S-424 70 5925				REG. NO.	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MRS. LENA D. SLAGLE				6/6/70 1:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTO, MD. 21231				A. STATE MARYLAND.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3406 E. FAIRMOUNT AVE.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/39	9. AGE (In years last birthday) 32
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME OWEN TURNER				14. MOTHER'S MAIDEN NAME FANNIE (UNKNOWN LAST NAME)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 216-10-0437		17. INFORMANT MRS. MILDRED HOERGER	
				ADDRESS 429 MARYLAND AVE, ESSEX, MD.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOGENIC SHOCK, MYOCARDIAL INFARCTION					
(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD.					
(C)					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/6 1970 to 6/6 1970 that (I) (we) last saw the deceased alive on 6/6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.C. Chouvalit, M.D.				23B. DATE SIGNED 6/6/70	
23C. PHYSICIAN'S NAME (Type) A.E. CHOUVALIT, M.D.				23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/9/70		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970			
25B. NAME OF REGISTRAR John E. [Signature]		25C. FUNERAL DIRECTOR Joseph Connelly, Son		25D. ADDRESS 300 [Address]	



BIRTH NO.

REG. NO.

VS 151-REV. 7/1/68

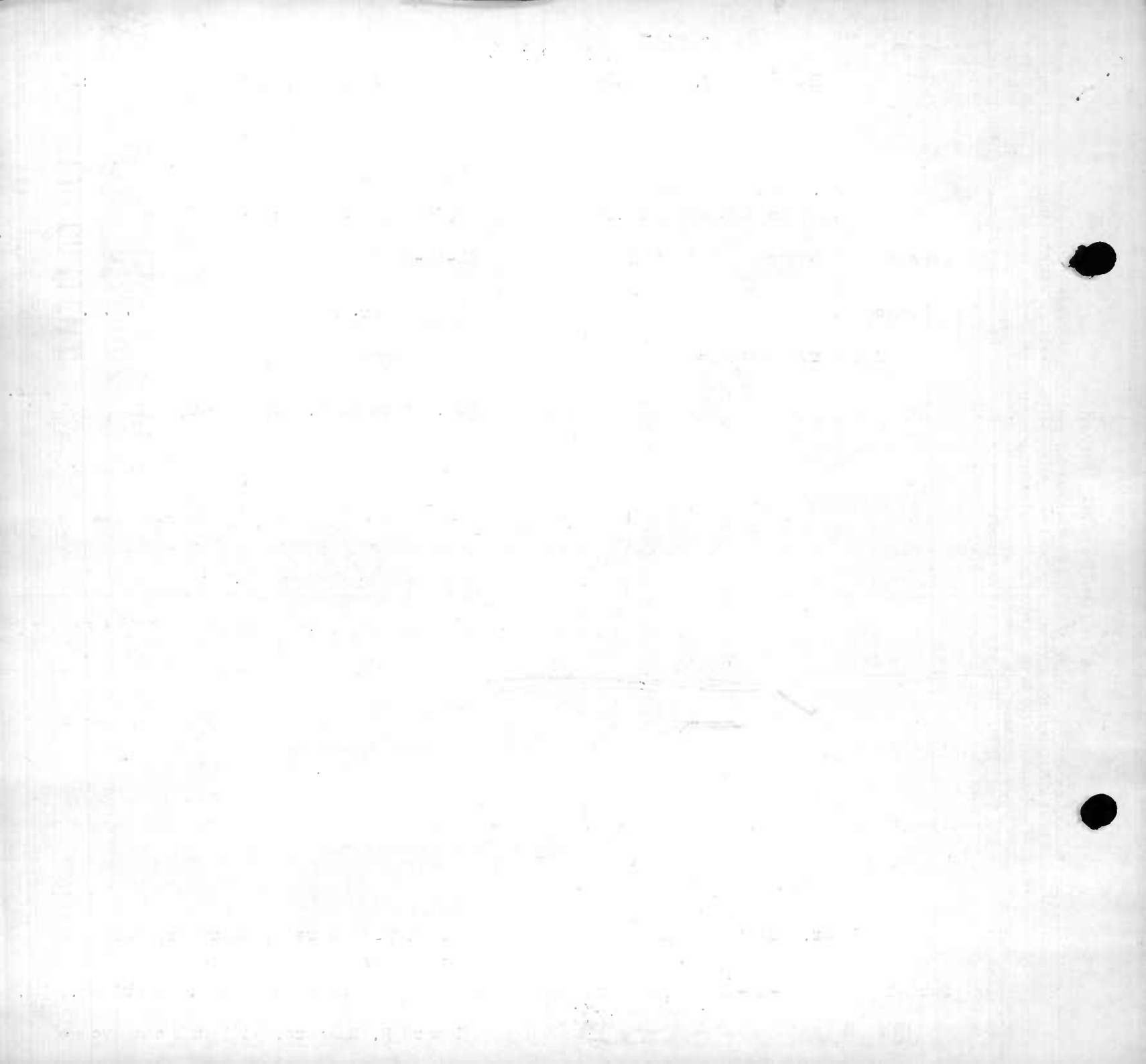
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5927	
BIRTH NO. 1-360		70 5927		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) IDA T. DUDROW			2. DATE AND HOUR OF DEATH June 7, 1970 9:57 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Wilkins & Caton Avenues			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN Harwood Park D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6905 Highland Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1881	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Theodore Sachse			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florence E. Reimsnider, 6905 Highland Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) Star Rt. humerus			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute coronary occlusion 2 days Cardio Vascular disease 18 yrs (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) Star Rt. humerus		
19A. DATE OF OPERATION 5 27 70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) her home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Jimmy Television	
21D. TIME OF INJURY (APPROX.) 5 27 70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Lost her balance	
22. I certify that (1) (this hospital) attended the deceased from June 6 1970 to June 7 1970, that (1) (we) last saw the deceased alive on June 6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Bruce Brumbaugh M.D.			23B. ADDRESS 5609 Main Street, Elkridge, Maryland		23C. DATE SIGNED 6/8/70
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6-10-1970		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery
24D. LOCATION Washington Blvd. Howard Co., Md.			24E. DATE REC'D BY HEALTH DEPT. JUN 10 1970		24F. NAME OF REGISTRAR Robert E. Taylor
24G. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Avenue			24H. ADDRESS 21229		24I. DATE 6/8/70





# FUNERAL DIRECTOR: IMPORTANT

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F-625 70 5928		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5928			
BIRTH NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) FRIESEN, WILLIAM CHARLES				2. DATE AND HOUR OF DEATH JUNE 6, 1970 10:15 P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL 40				A. STATE MARYLAND B. COUNTY BALTIMORE 21227 5300					
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER 1314 MAPLE AVENUE					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-01-13			
				9. AGE (In years last birthday) 57		11. BIRTHPLACE (State or foreign country) MARYLAND			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME CHARLES FRIESEN				14. MOTHER'S MAIDEN NAME MARY M. HOFBOWER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-26-0374		17. INFORMATION CATON AVE. BALTO; MD. ADDRESS 21229 ST AGNES HOSPITAL RECORDS-WILKENS &			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 230191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto Myocardial Infarction (B) ASCVD (C) Diabetes				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from JUNE 5 19 70 to JUNE 6, 19 70 that (X) (we) last saw the deceased alive on JUNE 6, 19 70 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (d) (XX) view the body after death.									
23A. SIGNATURE Ching-Hui Tsai, M.D.				23B. DATE SIGNED 6/7/70					
23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.				23D. ADDRESS St Agnes Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970				25B. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229			

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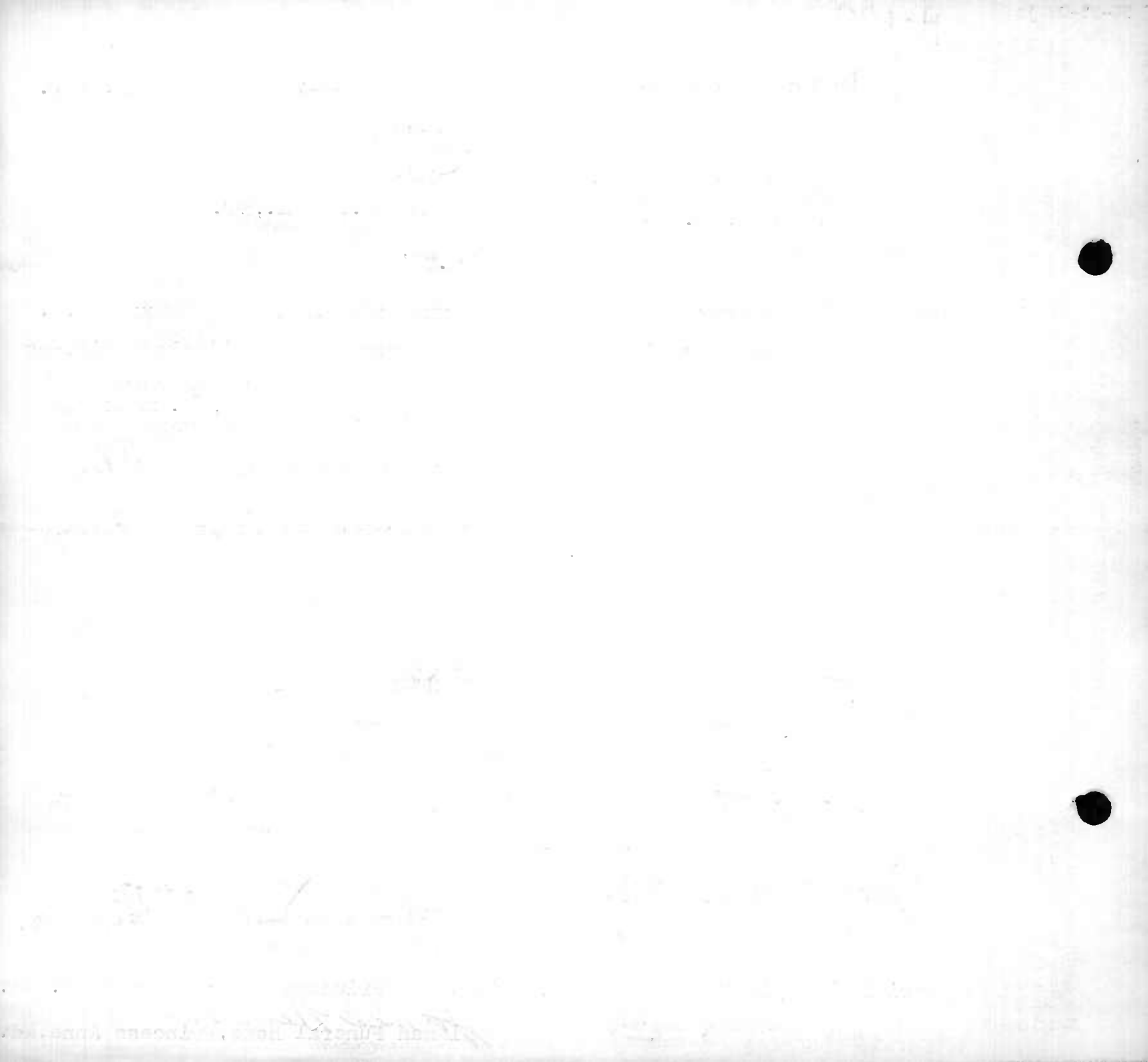
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70 5929 CERTIFICATE OF DEATH X REG. NO. 70 5929

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

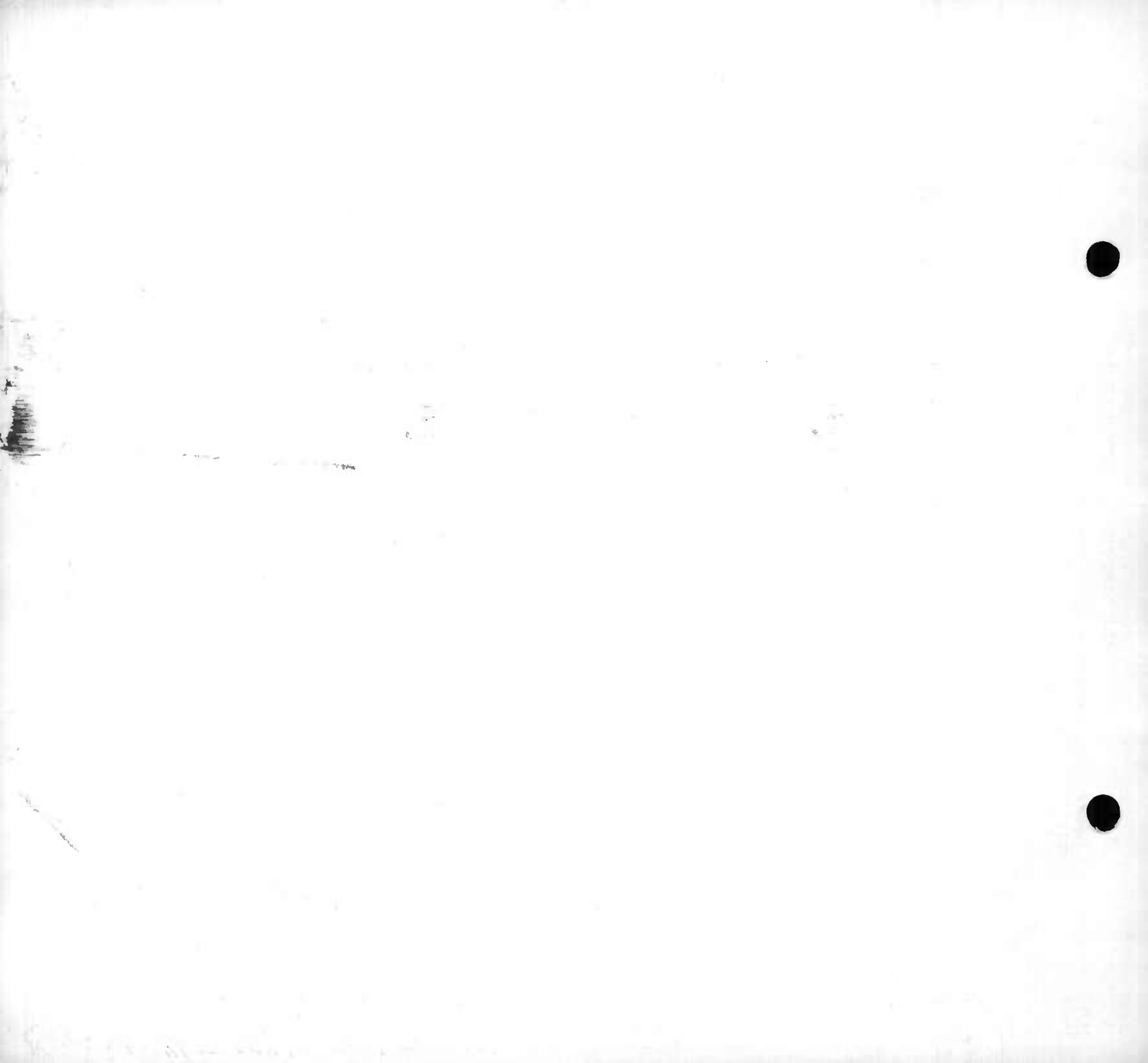
BIRTH NO. <u>H-620</u>		70 5929 CERTIFICATE OF DEATH X		REG. NO. 70 5929	
1. NAME OF DECEASED (Type or Print) <u>DORA HARRIS</u>			2. DATE AND HOUR OF DEATH <u>6-6-70</u> <u>10:45 p. m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31</u> <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>425 52nd St., Balto., Md. 21224</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1903</u>	9. AGE (in years lost birthday) <u>66</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Western Union Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>xxx</u>		11. BIRTHPLACE (State or foreign country) <u>xxx Princess Anne</u>	
12. CITIZEN OF WHAT COUNTRY? <u>xxx U.S.</u>		13. FATHER'S NAME <u>xxx James Harris</u>		14. MOTHER'S MAIDEN NAME <u>xxx Mary Elizabeth Gibbons</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH Records: 4940 Eastern Avenue Baltimore, Md. 21224</u>	
18. <u>4369 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 days</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u> <u>xxxx</u> <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>5/30</u> 19 <u>70</u> to <u>6/6</u> 19 <u>70</u> that (1) <u>we</u> last saw the deceased alive on <u>6/6</u> 19 <u>70</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>James R. Fonk M.D.</u>		23B. DATE SIGNED <u>6/6/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JAMES R. FONK M.D.</u>	
23D. ADDRESS <u>BALTO. CITY HOSP.</u> <u>4940 - EASTERN AVE</u>		23E. BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Emmanuel Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Princess Anne; Somerset Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taber</u>		25C. FUNERAL DIRECTOR <u>Winman Funeral Home, Princess Anne, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

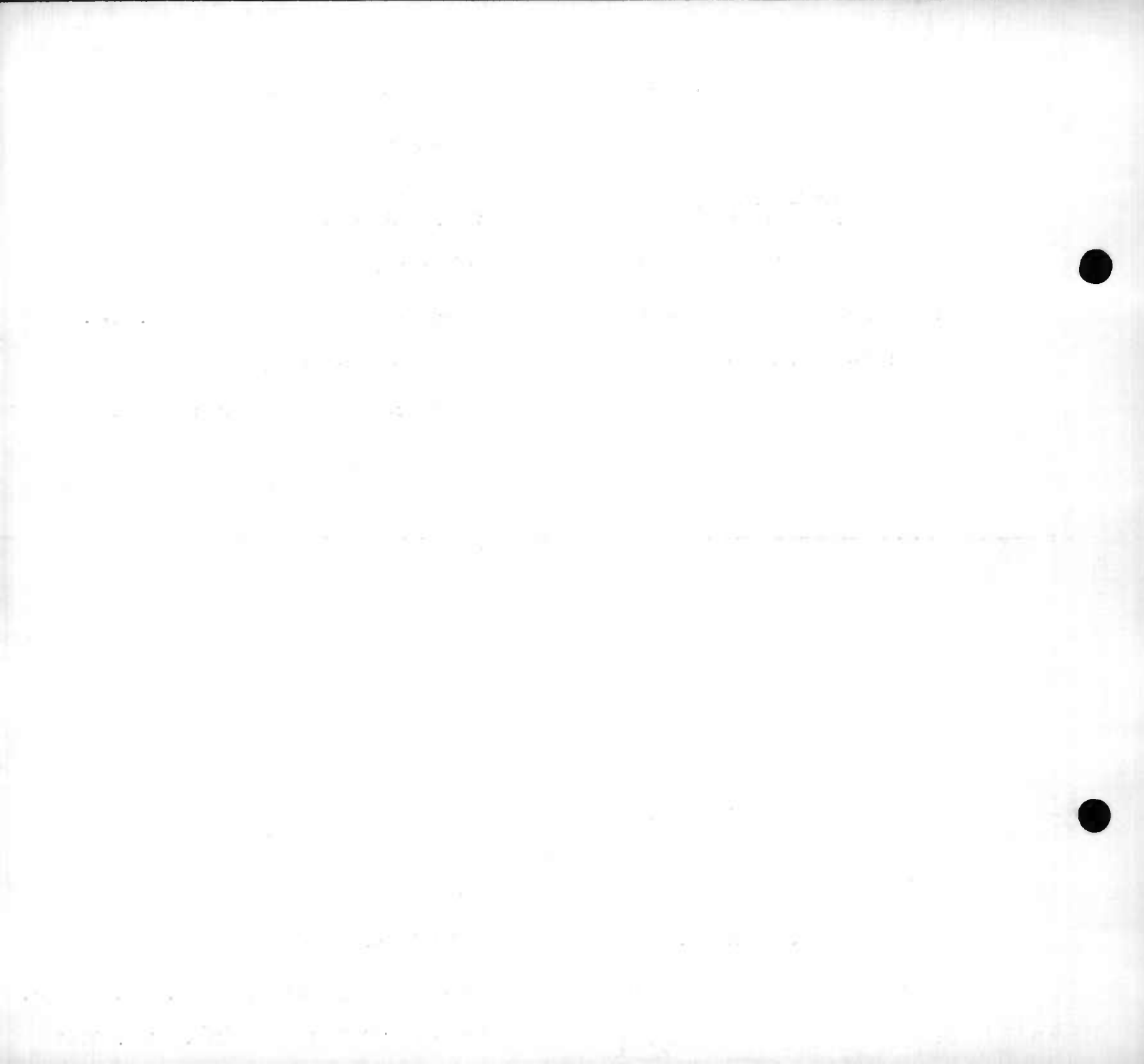
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">70 5930</span>					REG. NO. <span style="float: right;">70 5930</span>				
1. NAME OF DECEASED (Type or Print) <b>Edward J. Brown</b>					2. DATE AND HOUR OF DEATH <b>6/7/70 8:35 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>					A. STATE <b>md.</b> B. COUNTY <b>1703</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <b>Ba/to</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
					E. STREET AND NUMBER <b>738 Pierce St.</b>				
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-22</b>		9. AGE (in years last birthday) <b>48</b>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>labor</b>		11. BIRTHPLACE (State or foreign country) <b>Ba/to. Md</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Sam Jones</b>					14. MOTHER'S MAIDEN NAME <b>Hannah Brown</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-46578</b>		17. INFORMANT <b>old records</b>			ADDRESS	
18. <b>4319 I</b> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <b>cerebral hemorrhage</b>				
DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5</b>				
ANTECEDENT CAUSES					(B) <b>myocarditis</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO, OR AS A CONSEQUENCE OF:				
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>6/1/70</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>						
22. I certify that (1) (this hospital) attended the deceased from <b>1/27</b> 19 <b>66</b> to <b>6/7</b> 19 <b>70</b> that (1) (we) last saw the deceased alive on <b>6/7</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Hary More Lattin</b>					23B. DATE SIGNED <b>6/8/70</b>			23C. PHYSICIAN'S NAME (Type) <b>Robert E. Fisher, M.D.</b>	
23D. ADDRESS <b>University Hospital</b>					23E. FUNERAL DIRECTOR <b>Williams Funeral Home 3911 Lakewood St.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>6/11/70</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>			24D. LOCATION (City, town or county) (State) <b>Cedar Hill Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 10 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>			25C. FUNERAL DIRECTOR <b>Williams Funeral Home 3911 Lakewood St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-420		70 5931		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5931	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ruth R. Ellis				2. DATE AND HOUR OF DEATH June 9, 1970 9:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 University One 1 E. University Parkway				A. STATE Maryland B. COUNTY 1202			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1 E. University Parkway			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-2-1895	9. AGE (in years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Reid				14. MOTHER'S MAIDEN NAME Mamie Callaway			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Mary Ried		ADDRESS Atlanta, Ga.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 4/10/70 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchial pneumonia (B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5:50 19 to June 9 1970 that (I) (we) last saw the deceased alive on May 16 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Louis P. Hamburger				23B. DATE SIGNED 6/9/70		23C. PHYSICIAN'S NAME (Type) Dr. Louis P. Hamburger	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-70		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto., Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

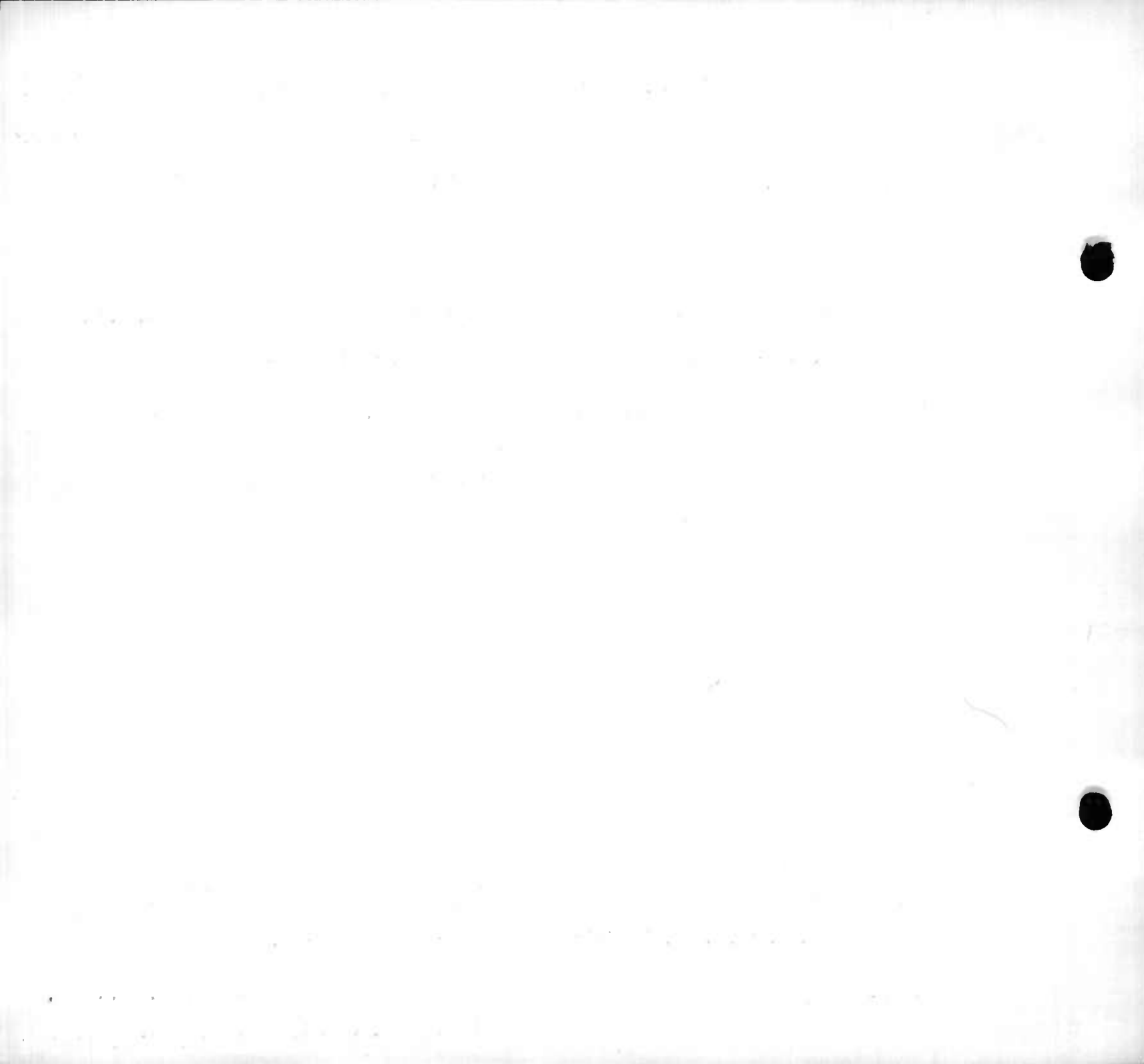




# FUNERAL DIRECTOR: IMPORTANT

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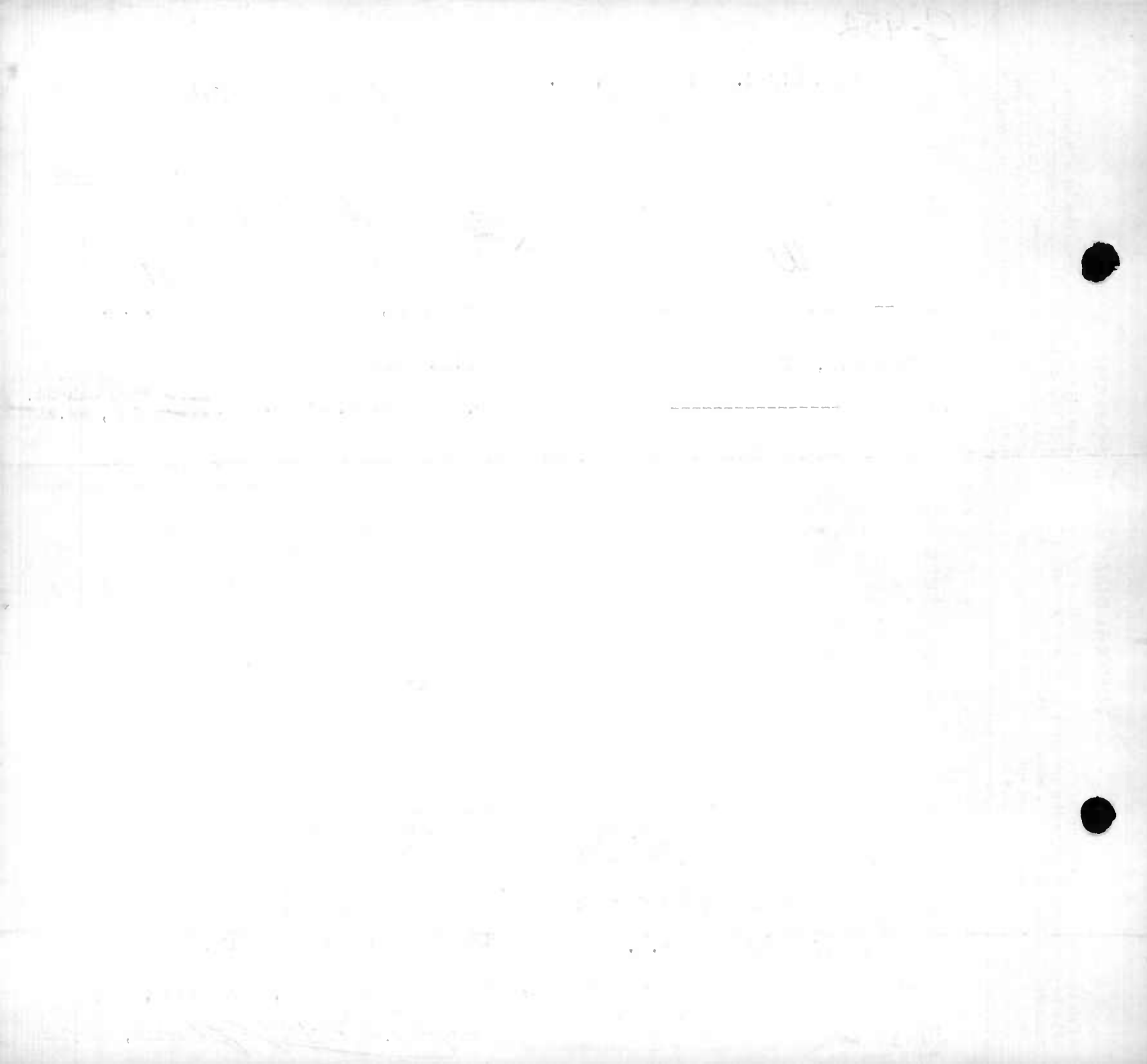
BALTIMORE CITY HEALTH DEPARTMENT		70 5932		70 5932	
BIRTH NO. <u>S-536</u>		70 5932		REG. NO. <u>70 5932</u>	
1. NAME OF DECEASED (Type or Print) <u>Aleida J. Snyder</u>			2. DATE AND HOUR OF DEATH <u>June 8, 1970</u> <u>10<sup>15</sup>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4709 Keswick Road</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2714</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4709 Keswick Road</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1882</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob H. Van't Hoff</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Mees</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-1930</u>	17. INFORMANT <u>Charles D. Snyder</u> ADDRESS <u>(Same)</u>		
18. <u>440.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Interictal seizure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>8 June 1970</u> that (I) (we) last saw the deceased alive on <u>8 June 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
22A. SIGNATURE <u>Wm. G. Helfrich MD</u>			22B. DATE SIGNED <u>9 June '70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Wm. G. Helfrich</u>			23D. ADDRESS <u>5006 Roland Ave.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/10/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</u>	



**FUNERAL DIRECTOR: IMPORTANT**

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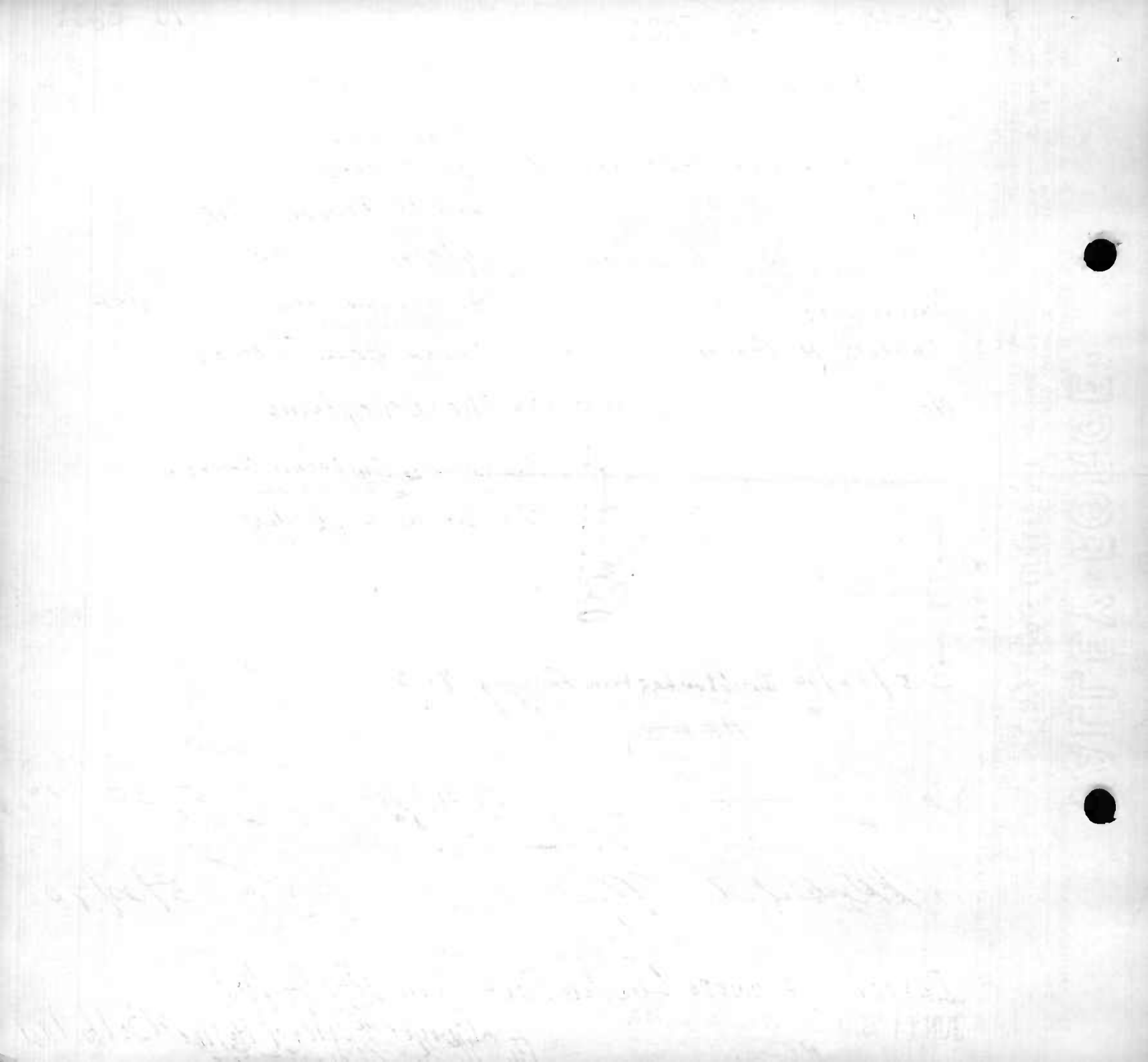
Baltimore City Health Department				REG. NO.	
C-452 70 5933		70 5933			
BIRTH NO. <i>Frederick, Md.</i>		5933		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>FRANKLIN D. CLINGERMAN, JR.</i>		2. DATE AND HOUR OF DEATH <i>June 7, 1970 8:00 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Frederick</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Frederick</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>1506 W 8th Street</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-19-70</i>	9. AGE (In years last birthday) <i>4 y 4 mo 19 d</i>	10. If Under 1 Yr. Months Days <i>19</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None--infant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>	
13. FATHER'S NAME <i>FRANKLIN, SR</i>		14. MOTHER'S MAIDEN NAME <i>LINDA FOX</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Franklin D. Clingerman</i>	
				ADDRESS <i>1506 West 8th St. Frederick, Md. 21701</i>	
18. <i>136 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Intracranial Bleed</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Thrombocytopenia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Congenital Infection</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>19 days</i> <i>19 days</i> <i>19 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (1) (this hospital) attended the deceased from <i>May 20</i> 19 <i>70</i> to <i>June 7</i> 19 <i>70</i> that (1) (we) last saw the deceased alive on <i>June 7</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Judith Hall M.D.</i>		23B. DATE SIGNED <i>June 7, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>JUDITH HALL M.D.</i>	
23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>		23E. NAME OF REGISTRAR <i>Robert E. Dailey, M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/9/1970</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Frederick, Frederick, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1970</i>			
25B. NAME OF REGISTRAR <i>Robert E. Dailey, M.D.</i>		25C. FUNERAL DIRECTOR <i>Robert E. Dailey &amp; Son</i>			
25D. ADDRESS <i>Frederick, Maryland</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 70 5934		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 5934	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>BESSIE MAE GRIM</b>		2. DATE AND HOUR OF DEATH <b>5/30/70 1:38 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2755</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND GENERAL HOSP.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2311 W. RODGERS AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>6/5/91</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANCIS H. GRIM</b>		14. MOTHER'S MAIDEN NAME <b>LAURA BELL TOOMEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 05 4706</b>		17. INFORMANT ADDRESS <b>The Wesley Home</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E884 X1</b>		CAUSE OF DEATH (A) <b>Pulmonary Embolus - Massive from L femoral</b> (B) <b>Fractured Left Hip</b> (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5/22/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intertracheal tube for Chf</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>Not Underlying</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2211 W. Rogers Ave 2755</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>5/22/70 approx 9 AM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>while cleaning, fell off chair</b>	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>5/21/70</b> 19 to <b>5/30</b> 1970, that (I) <del>(we)</del> last saw the deceased alive on <b>5/30</b> 1970 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(do not)</del> view the body after death.					
23A. SIGNATURE <b>Michael A. Ellis</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/30/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>2 June 70</b>		24C. NAME of CEMETERY or CREMATORY <b>Louisa Park Cem</b>	
24D. LOCATION <b>Balto Md</b>		24E. NAME of REGISTRAR <b>Robert E. Taylor, Jr.</b>		24F. FUNERAL DIRECTOR <b>Burger Funeral Home Balto Md</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		24H. ADDRESS <b>Burger Funeral Home Balto Md</b>			



1

B-620 70 5935 BALTIMORE CITY HEALTH DEPARTMENT

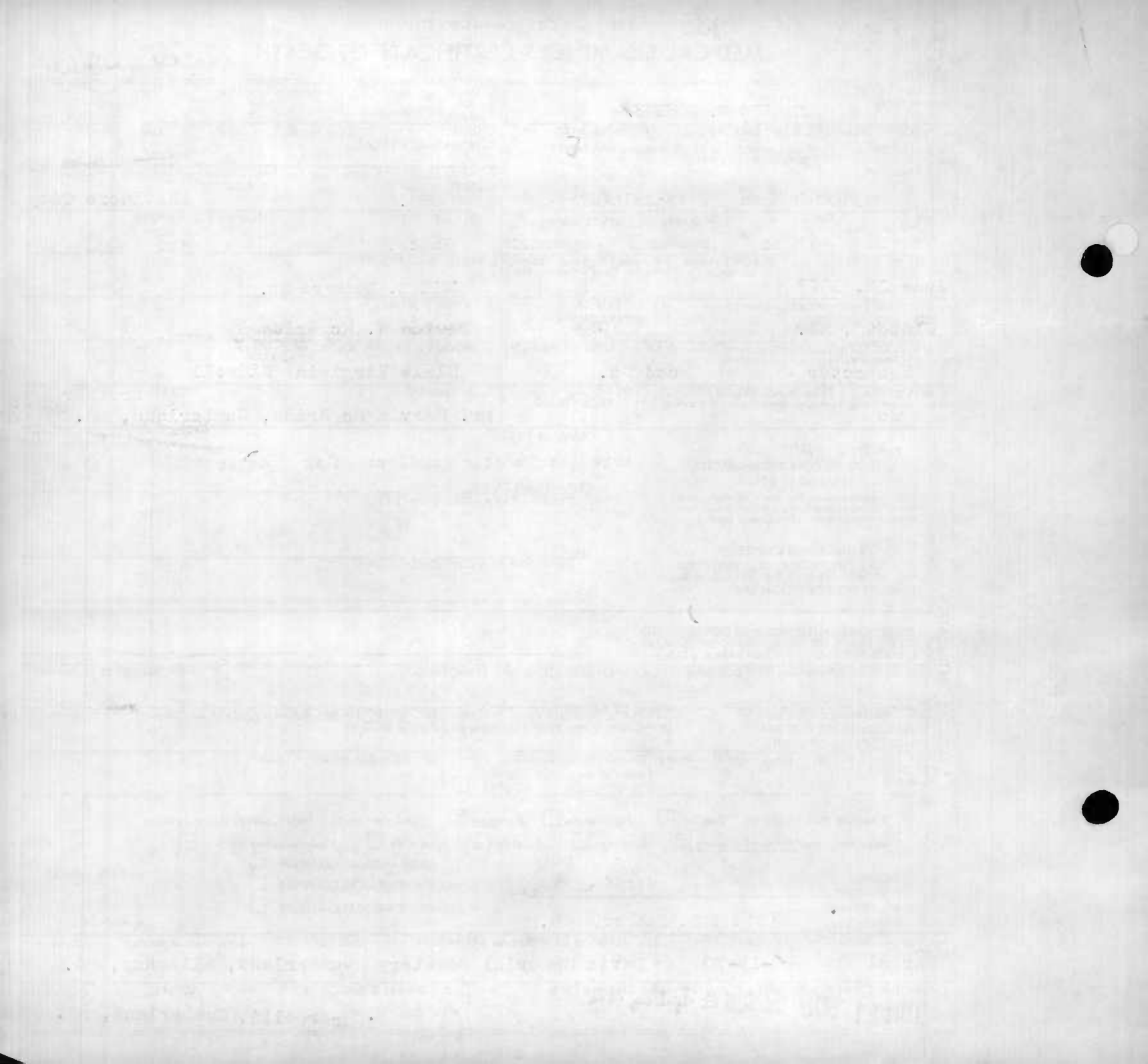
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5935

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NELLIE V. BOWERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 8 1970 7:31 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH June 22, 1923		10. AGE (In years lost birth day) 46?	
11. BIRTHPLACE (State or foreign country) Oldtown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		14B. KIND OF BUSINESS OR INDUSTRY Food Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Marvin Mc Bride, Cumberland, Md.		ADDRESS Brother	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 6-8-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-70	
24C. NAME OF CEMETERY or CREMATORY Davis Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Cumberland, Allegany, Md.	
25A. DATE REC'D BY HEALTH DEPT JUN 11 1970 Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	

VS 151-REV. 7/1/68

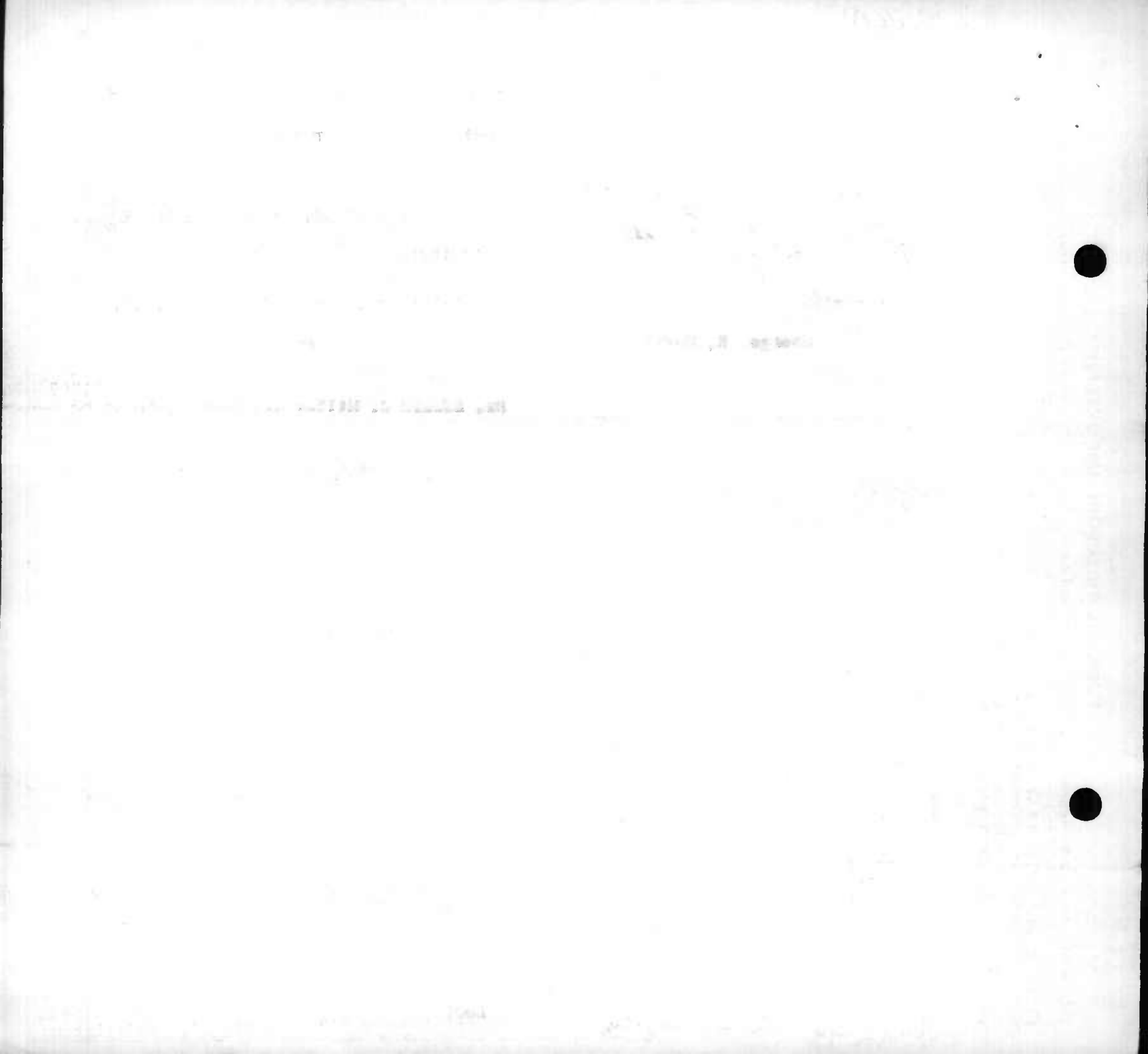




FUNERAL DIRECTOR: IMPORTANT

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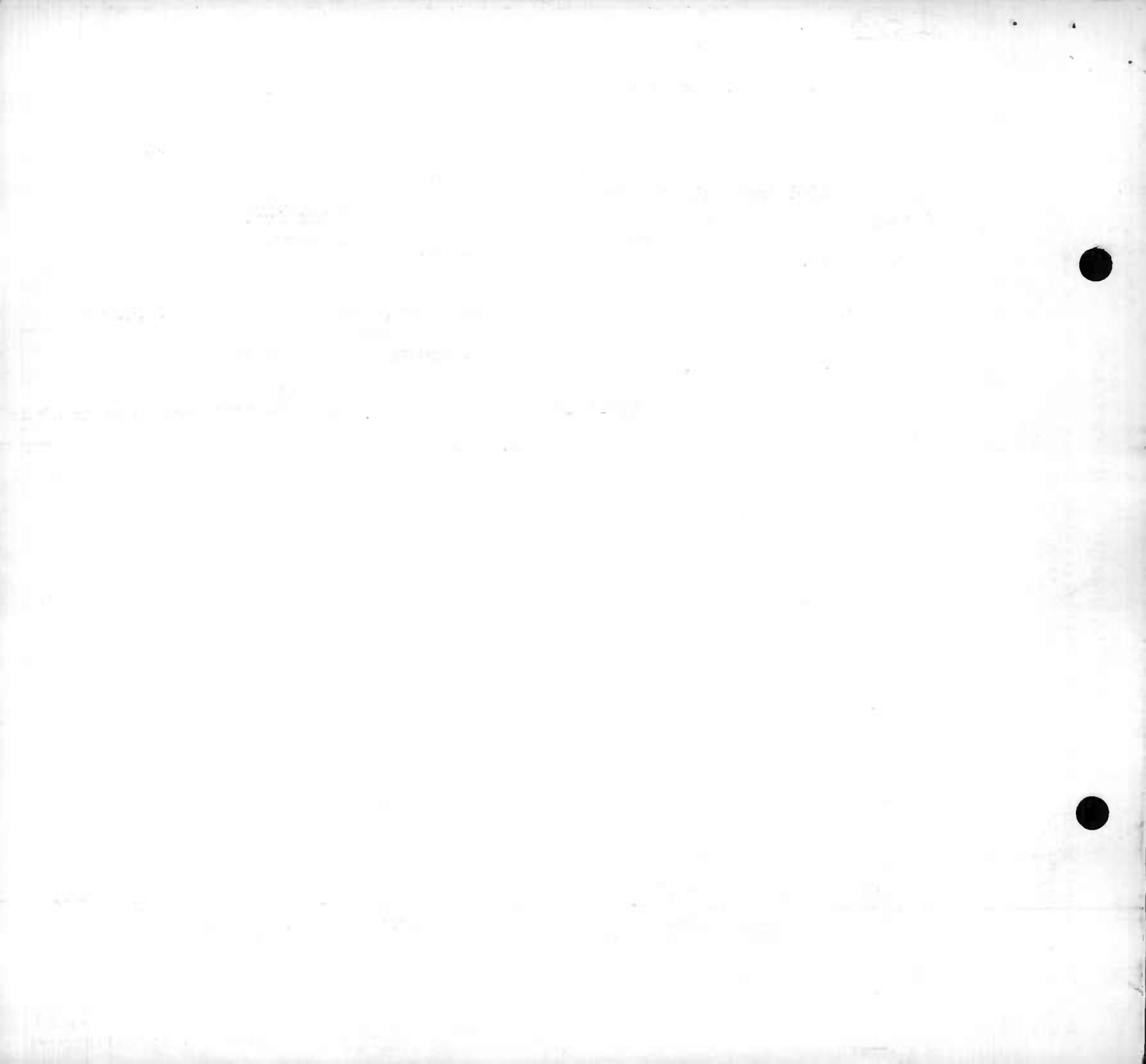
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 5936</u>	
17-460 70 5936				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Miller Catherine</u>				2. DATE AND HOUR OF DEATH <u>June 8 70 8:20 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp. of Balto.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3625 Lockwood Rd. Balto. Md. 21207</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/16</u>	9. AGE (in years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Edna Frey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Edward C. Miller Jr. 3625 Lockwood Rd</u>			
18. <u>331.0 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Huntington's chorea</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pneumonia</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 8 7pm 70 to June 8 8:20 pm 70</u> that (I) (we) last saw the deceased alive on <u>June 8 7:20 pm 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Hyun Taik Oh</u>				23B. DATE SIGNED <u>June 8 70</u>			
23C. PHYSICIAN'S NAME (Type) <u>HYUN TAIK OH</u>				23D. ADDRESS <u>Sinai Hosp. of Balto.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/11/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Loring Byers</u>			
				ADDRESS <u>8728 Liberty Rd. Randallstown</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>T-512</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5937</u>			
1. NAME OF DECEASED (Type or Print) <u>Bernard M. Thompson</u>				2. DATE AND HOUR OF DEATH <u>June 9, 1970</u>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4501 Park Heights Ave</u>				A. STATE <u>Maryland</u>				B. COUNTY <u>2716</u>			
				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>4501 Park Heights Ave.</u>							
5. SEX <u>Male</u>		6. RACE <u>Cau.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/28/19</u>		9. AGE (In years last birthday) <u>51</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard M. Thompson Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Genevive Tully</u>							
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-10-7368</u>		17. INFORMANT <u>21215</u> <u>Margarete R. Thompson 4501 Park Heights Ave.</u>				ADDRESS	
18. <u>10.94</u> <u>1</u> <u>571.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH <u>Acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Loenne's cirrhosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March 20, 1970</u> to <u>April 6, 1970</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>April 6, 1970</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <u>Seymour Rubin</u>				DEGREE <u>MD.</u>				23B. DATE SIGNED <u>June 9, 1970</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>5415 Park Heights Ave.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/12/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Rd. Randallstown</u>		<u>2133</u>			



R-520

70

5938

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

70

5938

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CAROL E. RAINES

2. DATE AND HOUR OF DEATH

6/7/70

2:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3236 Leverton Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-17-47

9. AGE (in years  
last birthday)

22

10. Under 1 Yr.  
Months11. Under 24 Hrs.  
Days

Hours

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. Y. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Williams Munker

14. MOTHER'S MAIDEN NAME

Mary Ann

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-50-1339

17. INFORMANT

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18.

201 X I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APLASTIC ANEMIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) MODERATE DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

17 MOS

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/18 19 70 to 6/7 19 70  
that (I) (we) last saw the deceased alive on 6-7 19 70 and that (in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arnold Levinson

M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

June 7, 1970

23C. PHYSICIAN'S  
NAME (Type)

Arnold Levinson M.D. DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6-10-70

24C. NAME OF CEMETERY OR CREMATORY

Crest Lawn Gardens

24D. LOCATION

(City, town, or county)

Howard County

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1970

25B. NAME OF REGISTRAR

James E. Jaber, M.D.

25C. FUNERAL DIRECTOR

Thelma R. Hoffmann

ADDRESS

3218 Hudson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



C-245

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5939

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES <sup>Luther</sup> / CHISOLM Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>June 8, 1970</b>		Month Day Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD <b>June 8, 1970</b>		8:08 P.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Oct. 16, 1914</b>		10. AGE (In years lost birthday) <b>55</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF <b>U.S.</b>		13. FATHER'S NAME <b>George R. Chisolm</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	
15. MOTHER'S MAIDEN NAME <b>Florence Stansel</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>253-09-2074</b>	
18. INFORMANT <b>Mrs. Gladys F. Chilolm</b>		19. ADDRESS <b>3900 Wilke Ave.</b>		20. ZIP CODE <b>21206</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic cardiovascular disease</b>		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. DATE OF OPERATION <b>6/12/70</b>	
25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
28. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		29. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		30. HOW DID INJURY OCCUR?	
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		33. DATE SIGNED <b>June 9, 1970</b>	
34. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		35. DATE <b>6/12/70</b>		36. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Pk</b>	
37. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		38. NAME OF REGISTRAR <b>John E. [Signature]</b>		39. FUNERAL DIRECTOR <b>McCall, F.N.</b>	
40. ADDRESS <b>37 Patapsco Ave.</b>		41. ZIP CODE <b>21225</b>		42. CITY, TOWN, or COUNTY (State) <b>Dorsey, Howard Co. Md.</b>	

10-21-1-



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

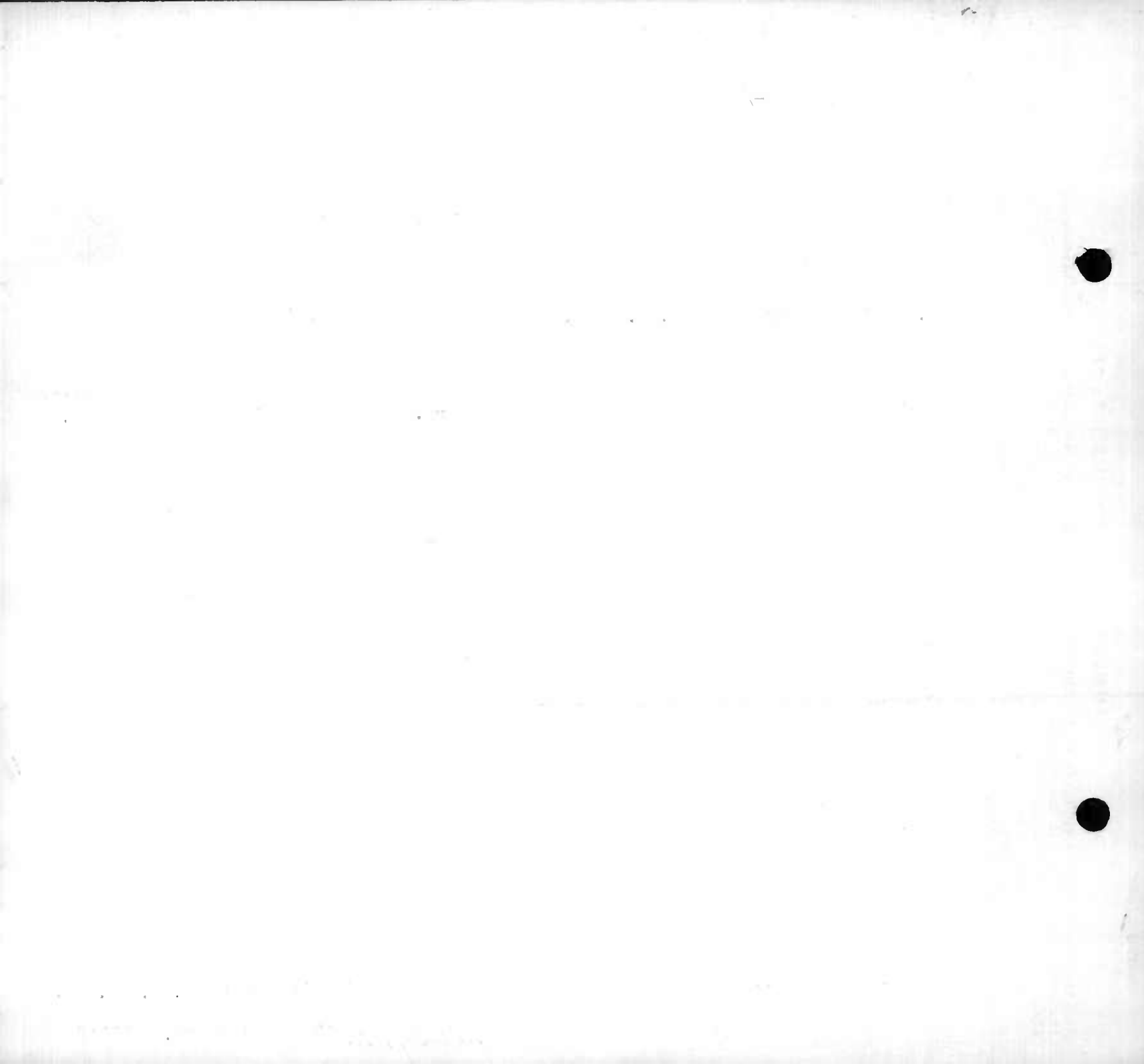
H-562		70 5940		BALTIMORE CITY HEALTH DEPARTMENT		70 5940	
CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">70 5940</span>			
1. NAME OF DECEASED (Type or Print) <b>HAMRICK, ARDEN G.</b>				2. DATE AND HOUR OF DEATH <b>June 6, 1970 11:00 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard 23 Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Uniontown</b> E. STREET AND NUMBER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/12/14</b>	9. AGE (in years last birthday) <b>55</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heavy equipment op</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (State or foreign country) <b>Wainville, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred Hamrick</b>				14. MOTHER'S MAIDEN NAME <b>Ann Barker</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11/10/42 - 11/28/45</b>		16. SOCIAL SECURITY NO. <b>232-18-1499</b>		17. INFORMANT ADDRESS <b>VA Hosp 3900 Loch Raven Blvd., Balto Md 21218</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-PULMONARY ARREST</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC BRAIN LESION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>PRIMARY-PROBABLY BRONCHOGENIC CA.</b> (C) UNDERLYING CONDITION LAST. <b>C.O.P.D.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (necly medical examined)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (Y) (this hospital) attended the deceased from <b>April 27th 19 70</b> to <b>June 6th 19 70</b> that (Y) (we) lost saw the deceased olive on <b>June 6th 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Andrew M. Doyle</b>				23B. DATE SIGNED <b>6/8/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ANDREW M. DOYLE MD</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6-11-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Louder Park National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.S.</b>		25C. FUNERAL DIRECTOR <b>Harry W. Haight</b>		25D. ADDRESS <b>Sykesville, Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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<p><b>E-145</b>      <b>70 5941</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b>      <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>70 5941</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="text-align: center;"><i>June 9, 1970 4:00 A.M.</i></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Hohan William Ebling</i></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>AN. CT</i></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 SOUTH BALTIMORE GENERAL HOSPITAL</i></p>		<p><b>C. CITY OR TOWN</b> <i>BALTIMORE</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <i>5507 MOORE ST BALTO 25</i></p>	
<p><b>5. SEX</b> <i>M</i></p>	<p><b>6. RACE</b> <i>W</i></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <i>3-25-87</i> <b>9. AGE (in years last birthday)</b> <i>83</i></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Ret. Cabinet Maker</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>U. S. Govt.</i></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>MD. Annapolis</i></p>
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i></p>		<p><b>13. FATHER'S NAME</b> <i>HENRY EBLING</i></p>	
<p><b>14. MOTHER'S MAIDEN NAME</b> <i>MARIE HOHAN</i></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)</p>	
<p><b>16. SOCIAL SECURITY NO.</b> <i>216-07-5475A</i></p>		<p><b>17. INFORMANT</b> <i>Mrs Elizabeth Ebling</i> ADDRESS <i>21225 5507 Moore St.</i></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>RENAL FAILURE</i></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <i>SEVERE CONGESTIVE HEART FAILURE</i></p>		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <i>ASCVD</i></p>	
<p><b>(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>		<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p><b>19A. DATE OF OPERATION</b> <i>0</i></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No) <i>No</i></p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <input type="checkbox"/> (Notify medical examiner)</p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>		
<p><b>22. I certify that (1) (this hospital) attended the deceased from <i>JUNE 3</i> 19 <i>70</i> to <i>JUNE 9</i> 19 <i>70</i> that (1) (we) last saw the deceased alive on <i>June 9</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>W. Eric John, M.D.</i></p>		<p><b>23B. DATE SIGNED</b> <i>6/9/70</i></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b></p>		<p><b>23D. ADDRESS</b> <i>South Balto Gen Hosp.</i></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <i>Burial</i></p>	<p><b>24B. DATE</b> <i>6/13/70</i></p>	<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Holy Cross</i></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Ritchie Highway A. A. Co. Md.</i></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JUN 11 1970</i></p>	<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Barber, Md.</i></p>	<p><b>25C. FUNERAL DIRECTOR</b> <i>McElly FH</i></p>	<p><b>ADDRESS</b> <i>237 Patapace Ave. 21225</i></p>



# FUNERAL DIRECTOR: IMPORTANT

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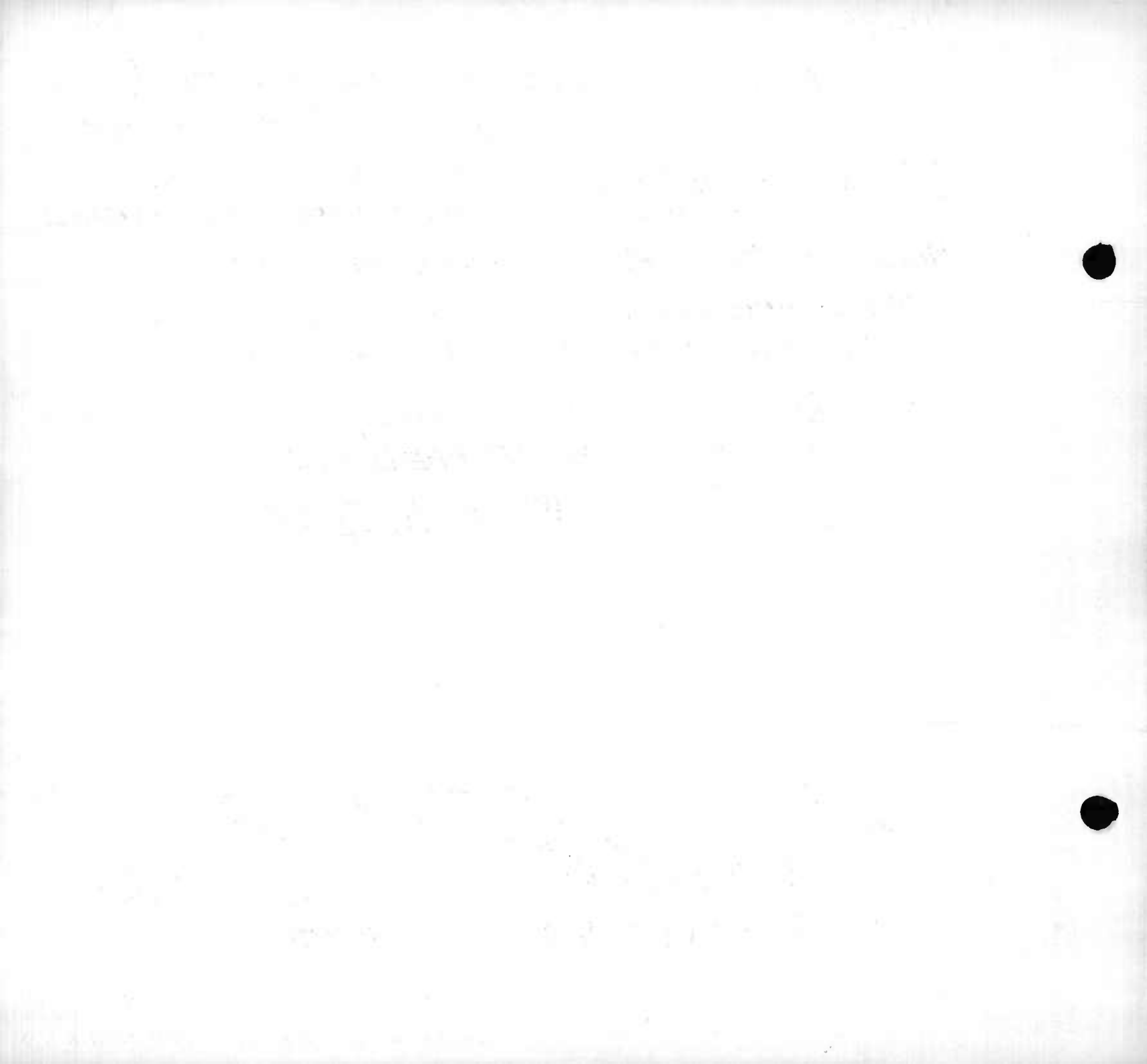
BALTIMORE CITY HEALTH DEPARTMENT									
70 5942					70 5942				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Seidl, Donald G					6/6/70 9:00 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
Univ. Md. Hospital 38					MD. BALTO. C.				
5. SEX					6. RACE				
M					W				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					4/7/26				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					9. AGE (In years last birthday)				
SEIDL-HEATING/AIR COND. SELF-EMPLOYED					44				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
BALTO.					U.S. A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Frank S. Seidl					Anna Krause				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
YES					220-18-7818				
17. INFORMANT					ADDRESS				
Chart					PERRY HALL				
MRS DOROTHY E. SEIDL					46 BANGERT AVE. 21128				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
2									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
yes									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED				
(Month) (Day) (Year) (Hour)					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
E. Seidl M.D.									
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					Univ. Md. Hosp. 27 S. Greene BALTO. MD.				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
BURIAL					10 JUNE 70				
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)				
GARDENS OF FAITH CEM					BALTO. MD.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
JUN 11 1970					25C. FUNERAL DIRECTOR				
					ADDRESS				
					LASSAUN FUNERAL HOME 7401 BELAIR RD.				



# FUNERAL DIRECTOR: IMPORTANT

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M-635 70 5943		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 5943	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARTIN GEORGE P.</b>		2. DATE AND HOUR OF DEATH <b>06-06-70 11:10 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ARMCO STEEL</b>		8. DATE OF BIRTH <b>04-10-04</b>	
13. FATHER'S NAME <b>OLIVER MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>LULA TURNER</b>		9. AGE (In years last birthday) <b>66</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>217-07-0224</b>		17. INFORMANT <b>DENZEL D. MARTIN</b> ADDRESS <b>4603 POWELL AVE. 21206</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA OF THE LUNGS</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>WITH MULTIPLE METASTASIS</b>		CAUSE OF DEATH <b>CA OF THE LUNGS</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>WITH MULTIPLE METASTASIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>05-29-70</b> to <b>06-06-70</b> and that (1) (my) last saw the deceased alive on <b>06-06-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. P. Mikus M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/6-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. P. MIKUS M.D.</b>		23D. ADDRESS <b>DMH</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JUNE 10, 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE CEM.</b>	
24D. LOCATION (City, town, or county) <b>DORSEY ANNE BRUNDLE MD</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>	
25A. FUNERAL DIRECTOR <b>LASSAHN FUNERAL HOME</b>		25B. ADDRESS <b>7401 BELAIR RD.</b>			

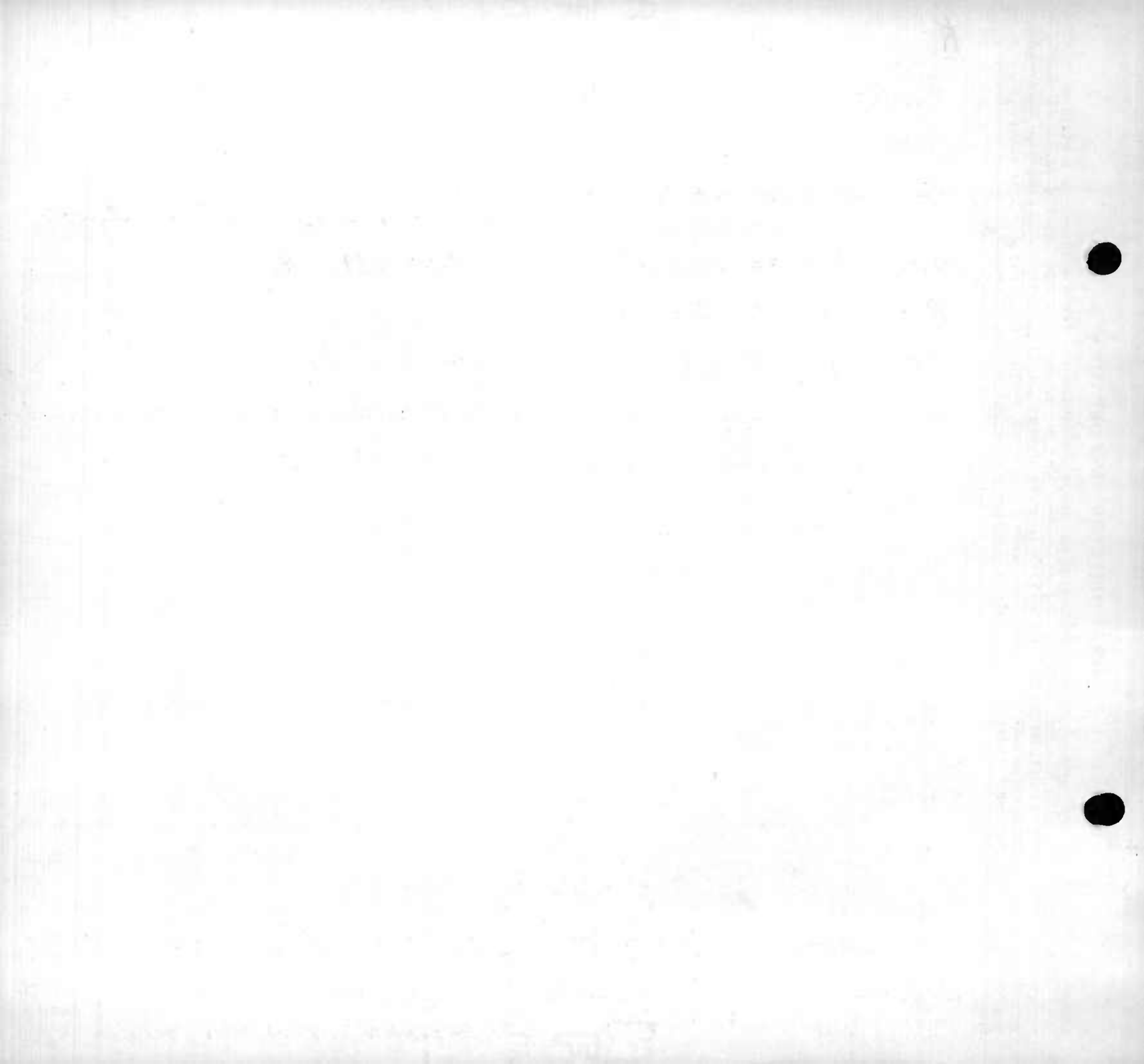




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

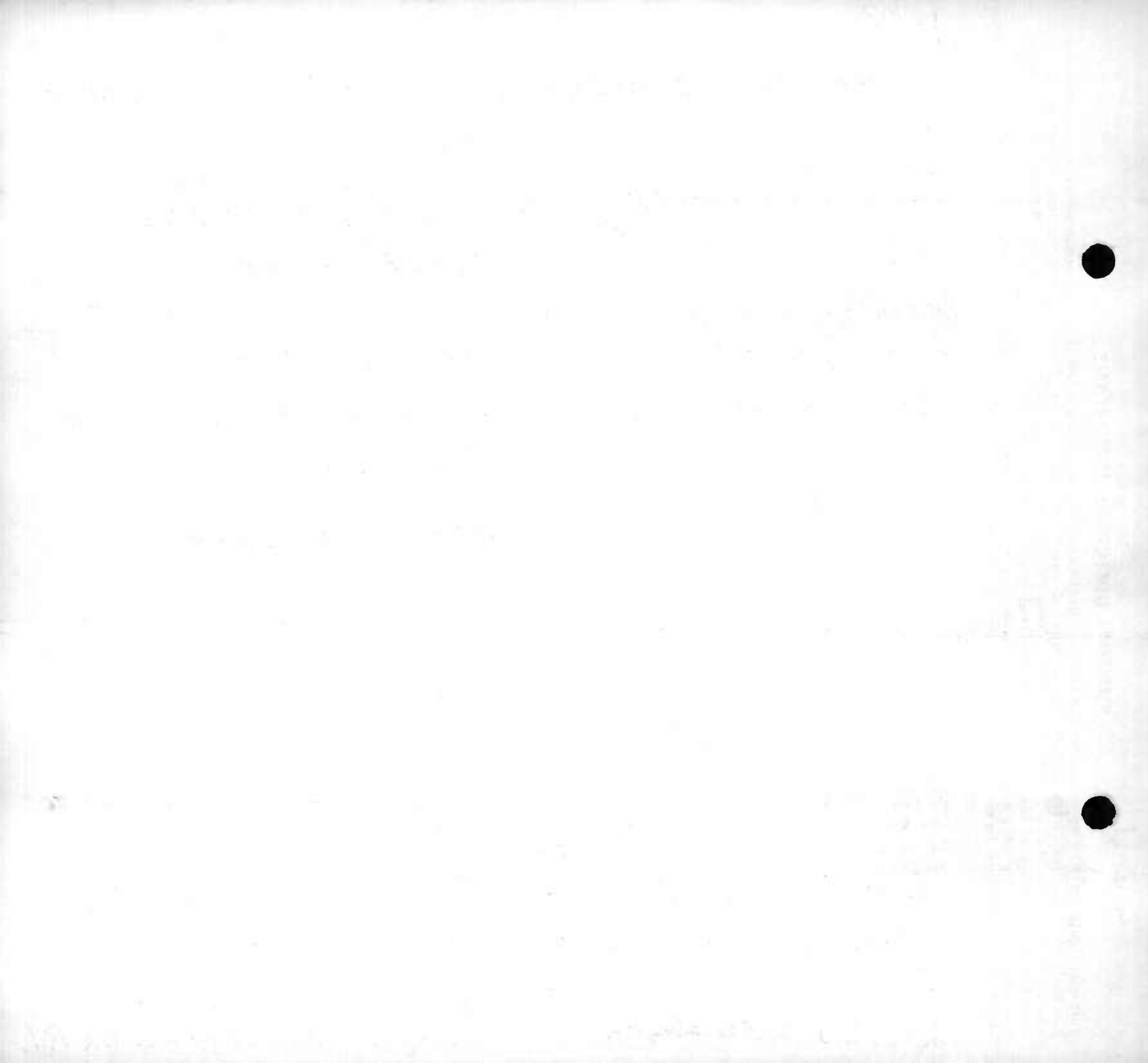
BALTIMORE CITY HEALTH DEPARTMENT									
70 5944					70 5944				
1. NAME OF DECEASED (Type or Print) <b>HENRY F. REIDER</b>					2. DATE AND HOUR OF DEATH <b>JUNE 7, 1970</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 GOULD NURSING HOME</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 4071 BABIKOW RD. 21237</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9, 1899</b>	9. AGE (In years last birthday) <b>71</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROAD REPAIR</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>HENRY REIDER</b>					14. MOTHER'S MAIDEN NAME <b>ANNA BECEL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>212-40-5971</b>		17. INFORMANT <b>MRS. DOROTHY E. NEELY</b>				ADDRESS <b>21236</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>153.8 I</b> <b>MECHANISTIC CARCINOMA of colon</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>S. I. Stern</b>					23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type) <b>Samuel Stern, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE			24C. NAME OF CEMETERY or CREMATORY	
<b>BURIAL</b>					<b>JUNE 10 - 70</b>			<b>MORELAND MEM. PARK BALTO. Co. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>			25C. FUNERAL DIRECTOR <b>LASSAUN FUNERAL HOME</b>	
								ADDRESS <b>7401 BELAIR RD. 21236</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 5945</u>
BIRTH NO. <u>A-123 70 5945</u>		1. NAME OF DECEASED (Type or Print) <u>ABICHT, ELMORE C.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>6/7/70 11:30 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MERCY HOSPITAL</u> <u>301 ST PAUL PLACE 21202</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2741</u>		
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SHIPPING CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ROWAN COMPTON CO.</u>		8. DATE OF BIRTH <u>08 12/11/08</u>
13. FATHER'S NAME <u>ABICHT, CHARLES</u>		14. MOTHER'S MAIDEN NAME <u>MALTHAM, LOUISA</u>		9. AGE (In years last birthday) <u>61 60</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-18-6701</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>
17. INFORMANT <u>MRS. DOROTHY V. ABICHT</u>		ADDRESS <u>SAME</u>		
18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONITIS -</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>METASTATIC CARCINOMA.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(N)</u> (this hospital) attended the deceased from <u>6/2</u> 19 <u>70</u> to <u>6/7</u> 19 <u>70</u> that <u>(N)</u> (we) last saw the deceased alive on <u>6/70</u> 19 <u>70</u> and that <u>(N)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(N)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Patrick A. Molony MD</u>		23B. DATE SIGNED <u>6/7/70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>PATRICK A. MOLONY MD</u>		23D. ADDRESS <u>MERCY HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-10-70</u>		24C. NAME of CEMETERY or CREMATORY <u>LORRAINE PARK CEMETERY</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>J. Walter Conklin</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>		ADDRESS <u>5444 BELAIR Rd.</u>		



# FUNERAL DIRECTOR: IMPORTANT

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W-436 70 5946		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5946	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLWOOD WILDERSON III		2. DATE AND HOUR OF DEATH 6-9-70 8:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSP BALTIMORE, M.D.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-20-26		9. AGE (in years last birthday) 43		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCKSMITH		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ELLWOOD C. WILDERSON II		14. MOTHER'S MAIDEN NAME Birdie I. WILSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-22-9955		17. INFORMANT Mrs Pearl A Wilderson 5306 Sipple Ave 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH "SHOCK LUNG" POST THORACOTOMY CARCINOMA OF LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 6-4-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of lung	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5-18-1970 to 6-9-1970 that (1) (we) last saw the deceased alive on 6-9-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Shaffer M.D.		23B. DATE SIGNED 6-9-70	
23C. PHYSICIAN'S NAME (Type) J. Shaffer M.D.		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6/10/70		24C. NAME of CEMETERY or CREMATORY Greemount Crematory	
24D. LOCATION Balto		24E. NAME of REGISTRAR Robert E. Fisher, Jr.		24F. FUNERAL DIRECTOR Leonard J. Ruck Inc Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

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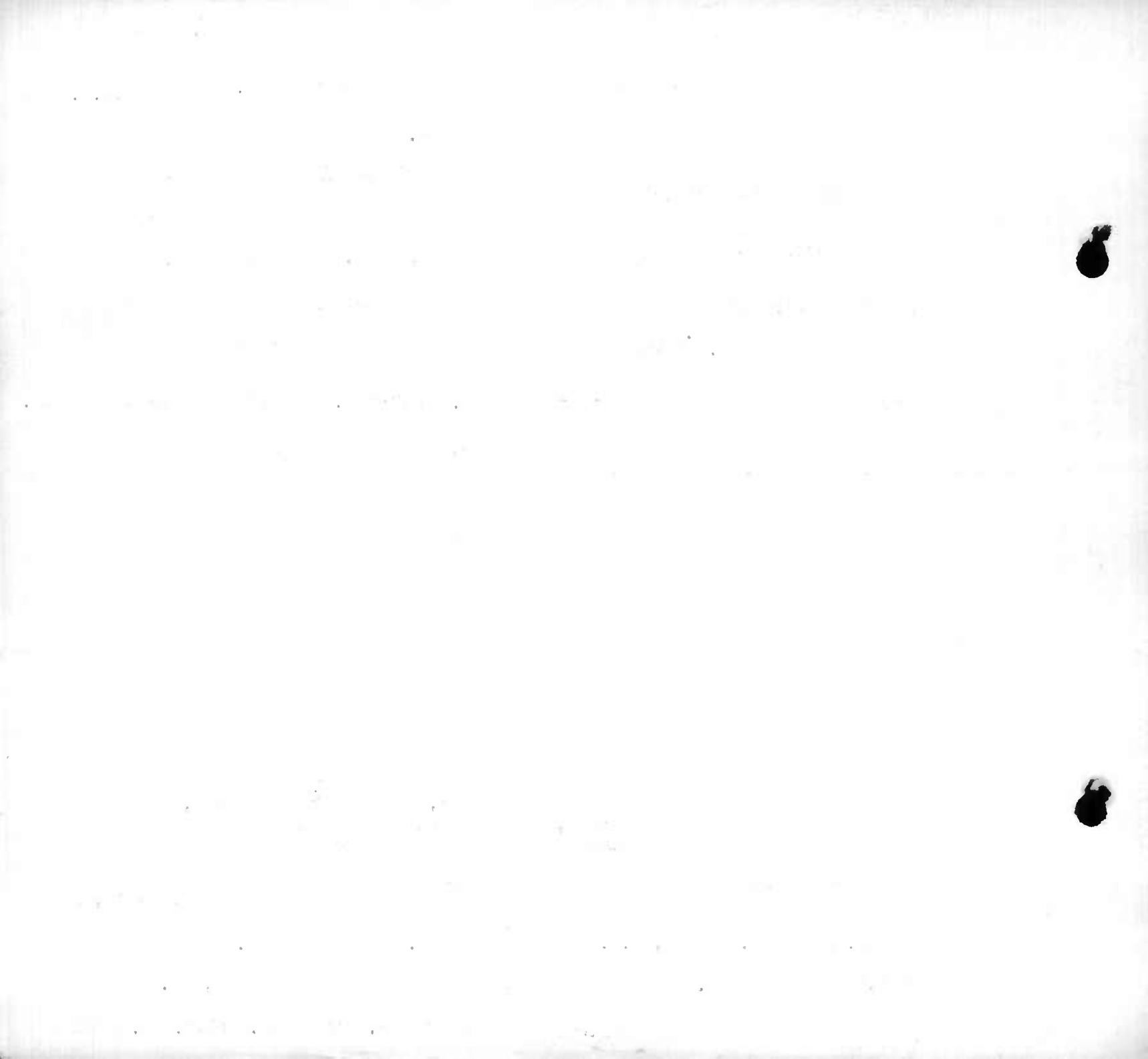
2000-01-01 10:00

2000-01-01 10:00

FUNERAL DIRECTOR: IMPORTANT

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B-500		70 5947		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5947		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) <b>ALBERT LEO BOWEN</b>					2. DATE AND HOUR OF DEATH <b>June 9, 1970. 8:A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 3512 Elliott Street</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2609</b>					
					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <b>3512 Elliott Street</b>					
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1896.</b>		9. AGE (In years last birthday) <b>74</b>		
						If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>John X. Bowen</b>					14. MOTHER'S MAIDEN NAME <b>Octavia Evans</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b>		If yes, give war or dates of service <b>WW I</b>		16. SOCIAL SECURITY NO. <b>212-10-1280</b>		17. INFORMANT ADDRESS <b>Mr. Clifton R. Bowen, 7835 Westmoreland Ave.</b>				
18. CAUSE OF DEATH										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>412.2 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Hypertensive Cardiovascular Disease</b></p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>Arteriosclerosis</b></p> </div> <div style="width: 50%;"> <p><b>(A) IMMEDIATE CAUSE</b></p> <p><b>DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(C) _____</b></p> </div> </div>										
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1970</b> to <b>June 8, 1970</b> that (I) (we) last saw the deceased alive on <b>June 8, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Melito M. Torres</i>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>June 10, 1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. Melito M. Torres, M.D.</b>					23D. ADDRESS <b>441 S. Ellwood Avenue.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/12/70.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS				

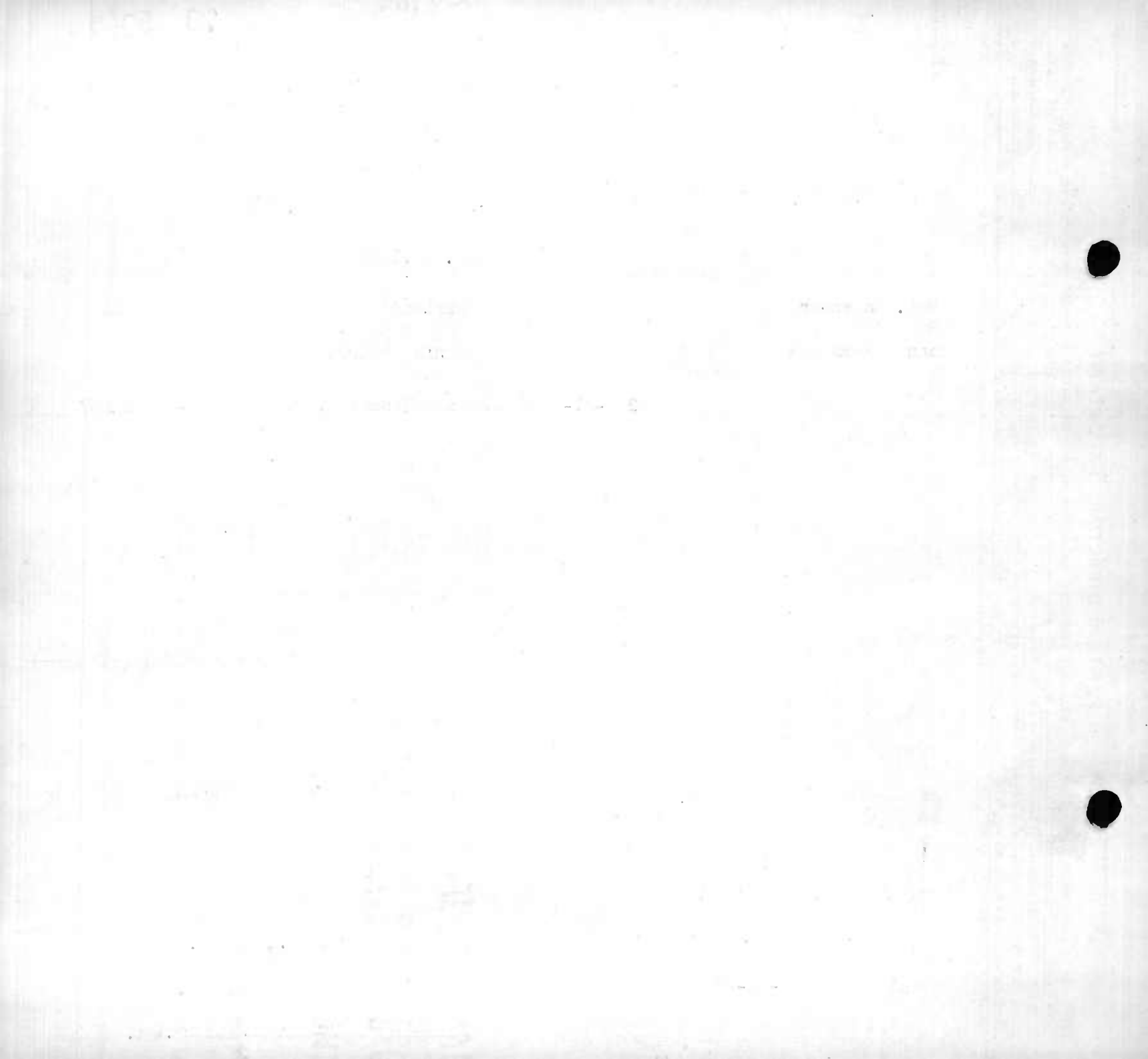




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5948</span>	
H-212 BIRTH NO.		70 5948		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">FRANCIS S. HOSSBACH, SR.</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 9, 1970 12:20 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">90 Long Green Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">1307</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">XXXX Roland Ave. 3939</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Aug. 28, 1892</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">77</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Ret. Salesman</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">John E Hossbach</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Annie Schirle</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WWI</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-01-2285</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">James M Hossbach, RR#1 Box 43-5 21057</span>	
18. <span style="font-size: 1.5em;">161.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH <span style="font-size: 1.5em;">Generalized metastatic Carcinomatosis</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Carcinoma of larynx</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">7 years</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11 Jan 1962</span> to <span style="font-size: 1.2em;">June 9th 1970</span> , that (I) <span style="font-size: 1.2em;">yes</span> lost saw the deceased alive on <span style="font-size: 1.2em;">May 30 1970</span> and that in (my) <span style="font-size: 1.2em;">own</span> opinion death occurred on the date and hour and from the causes stated above. (I) <span style="font-size: 1.2em;">(did)</span> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Hans J. Koetter</span>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Hans J. Koetter</span>				23D. ADDRESS <span style="font-size: 1.2em;">5600 Harford Rd., Balto. Md</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">6-12-70</span>		<span style="font-size: 1.2em;">Lorraine Park Cemetery</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.5em;">JUN 11 1970</span>		<span style="font-size: 1.2em;">Robert E. Fisher, R.D.</span>		<span style="font-size: 1.2em;">Leonard J Ruck Inc. Balto. Md. 21214</span>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
<span style="font-size: 1.2em;">Baltimore, Md.</span>		<span style="font-size: 1.2em;">Baltimore, Md.</span>			



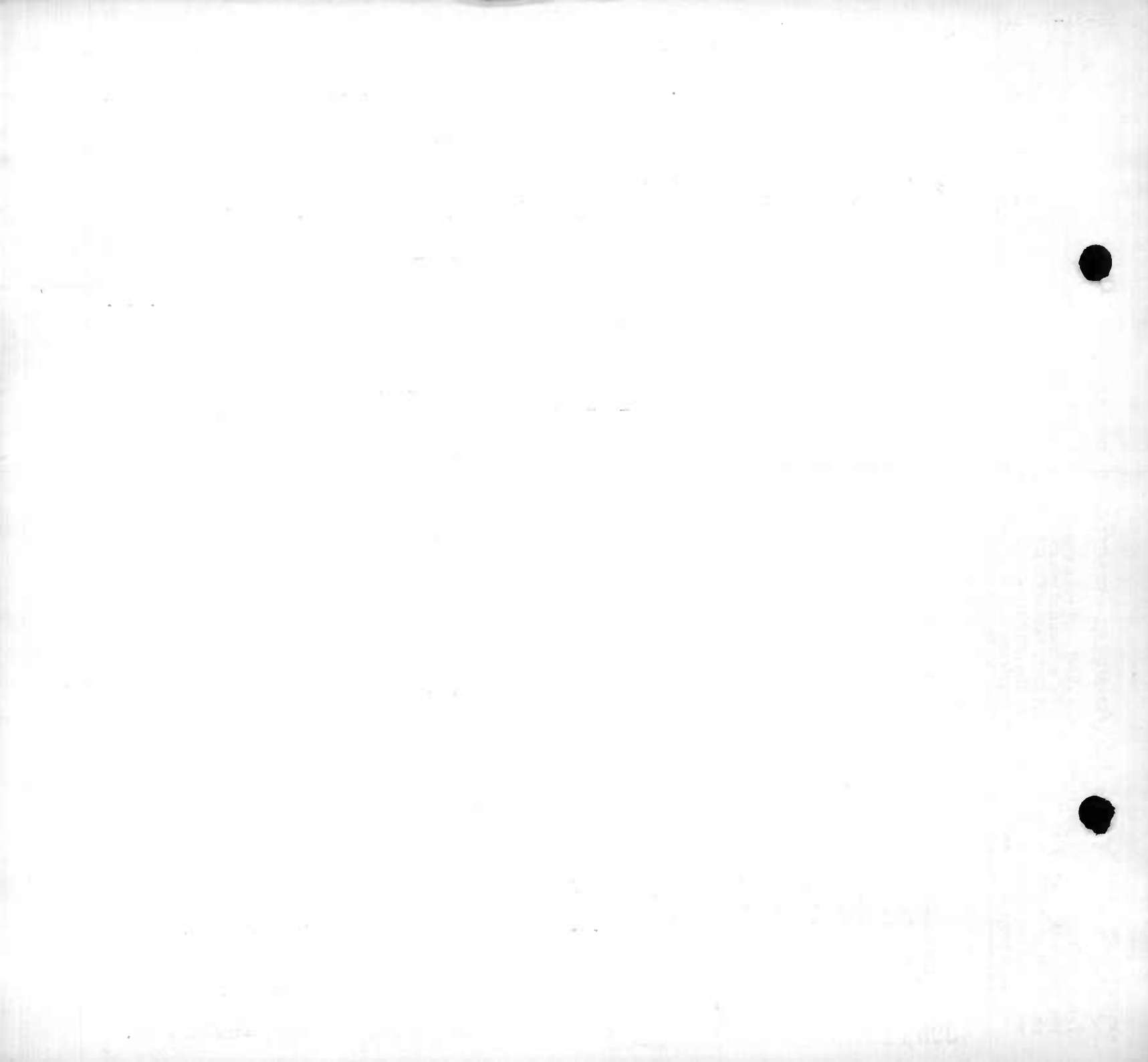
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">70 5949</span>
BIRTH NO. <span style="font-size: 1.5em;">S-100</span>				
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HARRY C. SCHUPP</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">June 6, 1970</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">31 Baltimore City Hospitals</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Dundalk</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2614 Plainfield Road</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">June 17, 1887</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Bookkeeper</span>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <span style="font-size: 1.2em;">82</span>
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Christian Schupp</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Maggie Miller</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Mrs. June Cicone, 2614 Plainfield Road.</span>
18. <span style="font-size: 1.5em;">412.317-2509</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)   II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">Diabetes Mellitus</span>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6/1/70</span> 19 to <span style="font-size: 1.2em;">6/6/70</span> 19 that (I) <del>may</del> last saw the deceased alive on <span style="font-size: 1.2em;">6/6/70</span> 19 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Manuel P. De Leon</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">6/8/70</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Manuel P. De Leon, M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">7840 Eastern Ave.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">6/9/70</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Baltimore Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 11 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert C. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Ulrich Funeral Home</span>
ADDRESS <span style="font-size: 1.2em;">4210 Belair Road.</span>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-620 70 5950		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5950	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
CROSS, ORLANDO G.				2. DATE AND HOUR OF DEATH 6-9-70 2:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224				A. STATE B. COUNTY MARYLAND BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31				E. STREET AND NUMBER 261 Patapsco Ave. #21222			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-79	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ? Cross			14. MOTHER'S MAIDEN NAME ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-58-6864		17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest (B) Sepsis DUE TO, OR AS A CONSEQUENCE OF: Urinary tract infection (C) Dehydration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 1 wk 1 wk	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Dehydration							
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from 6-7 19 70 to 6-9 19 70 that (I) (we) last saw the deceased alive on 6-9 19 70 and that (I) (my) (our) apinton death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R Brechtel				23B. DATE SIGNED 6-9-70		23C. PHYSICIAN'S NAME (Type) JOHN R BRECHTEL M.D.	
23D. ADDRESS 4940 EASTERN AVENUE #21224				23E. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/70		24C. NAME of CEMETERY or CREMATORY Elkton Cemetery		24D. LOCATION (City, town, or county) (State) Elkton, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.			



1  
L-100 70 5951 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 5951

1. NAME OF DECEASED (Type or Print) <b>AUDREY R. LEVY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 6 70 2:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2000 E. Federal St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 6, 1970 2:00 p.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1-10-30</b>		10. AGE (In years lost birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>md</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>CLARA Smith</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>216-24-3571</b>		18. INFORMANT <b>MARGARET SHAW</b>	
19. CAUSE OF DEATH <b>446.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Thrombotic thrombocytopenic purpura</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pernicious anemia</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION <b>2</b>	
21. AUTOPSY? (Yes or No) <b>YES</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Arbutus mem. Pk</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/11/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus mem. Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Isidore Mihalakis, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph B. Locks</b>		25D. ADDRESS <b>1304 N. Con...</b>	

Letter from M.E.'s office

8-20-70

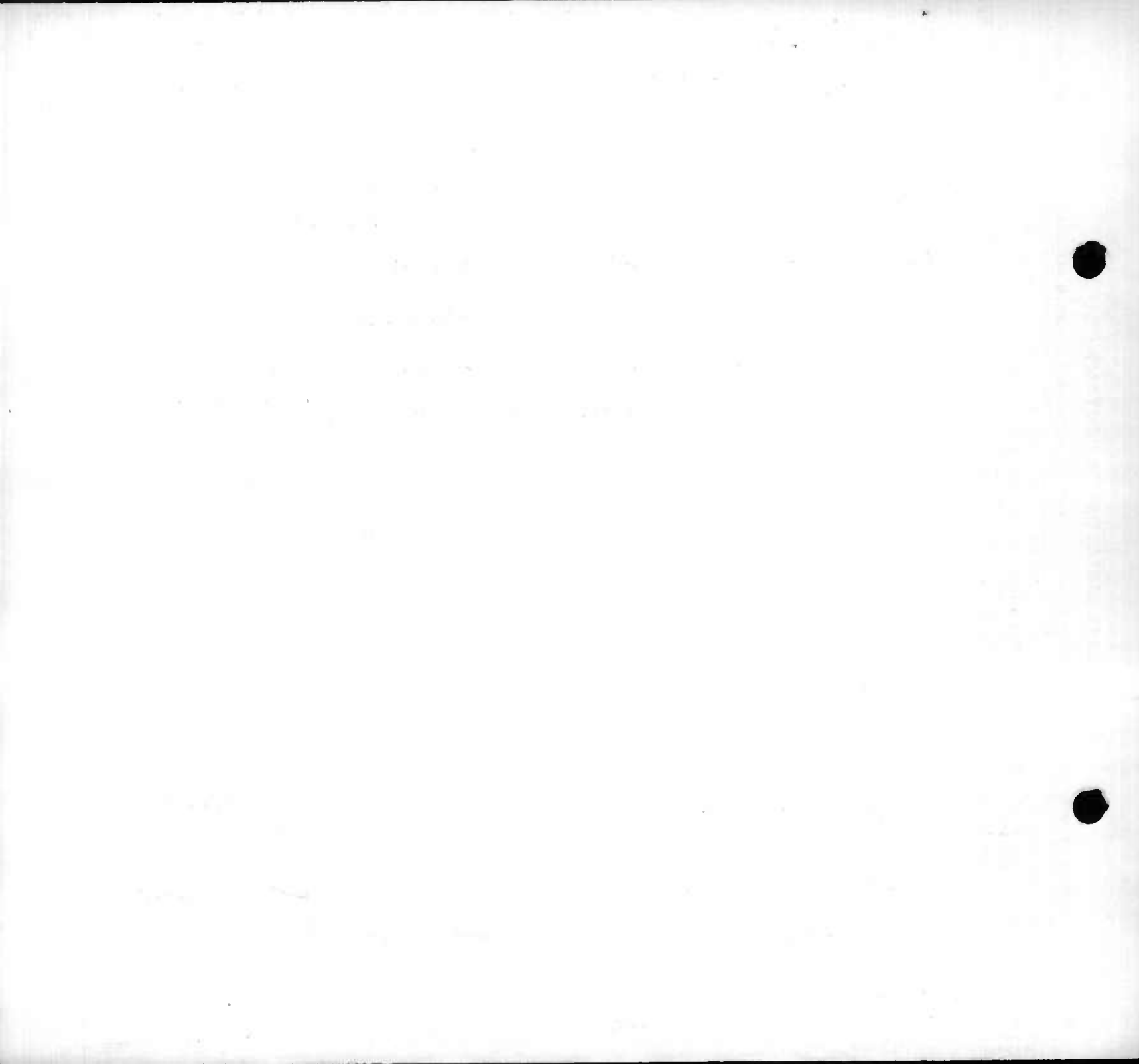
M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-635 70 5952				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 5952	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>James T. Wroten</b>		2. DATE AND HOUR OF DEATH <b>6/10/70 6/10/70 4:12 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>18 Maryland General Hosp. (Maryland General Hospital)</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>402 Forest Lane</b>			
5. SEX <b>M</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-87</b>	9. AGE (in years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MTA</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Edward Wroten - (Dec.)</b>				
14. MOTHER'S MAIDEN NAME <b>Amelia Parks (Dec.)</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>213-10-3031</b>			17. INFORMANT <b>chart Mrs. Margaret W. Bauer</b> ADDRESS <b>402 Forest Lane</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>441.914.185X</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prob. Rupt. Aortic Aneurysm</b>		<b>5 minutes</b>	
				(B) <b>erosion of Ca Prostate</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1-2 yrs.</b>	
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>16/4/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>urinary tract obst.</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6-2-70</b> 19 to <b>6/10/70</b> 19 that (I) (we) last saw the deceased alive on <b>6/10</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lloyd B. Mandel</b>				23B. DATE SIGNED <b>6/6/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>Lloyd B. Mandel</b>				23D. ADDRESS <b>Maryland General Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/13/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave.,</b>		ADDRESS <b>21228</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

70 5953

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BESSIE BROWN

2. DATE AND HOUR OF DEATH

6-9-70

8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)90 Hood Convalescent Home  
5313 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

E. STREET AND NUMBER

North Bend &amp; Edmondson Avenue

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7-30-79

9. AGE (In years  
last birthday)

90

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

unknown

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Brown

14. MOTHER'S MAIDEN NAME

Mary

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Frank Baker, Jr.

ADDRESS

3113 The Oaks Road  
Ellicott City Md.

18. 412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-23-1955 to 6-9-1970,  
that (I) ~~we~~ last saw the deceased alive on 6-8-1970 and that in (my) ~~our~~ opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~We~~ (did) (did not) view the body after death.

23A. SIGNATURE

Harry L. Knipp, MD.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

6-9-70

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

4116 EDMONDSON AV.  
BALTIMORE, MD. 2122924A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

6/11/70

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 11 1970

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Witzke Inc.

1630 Edmondson Ave.

5206 GWYN OAK AVE.  
ENTERED NH 6/3/70.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

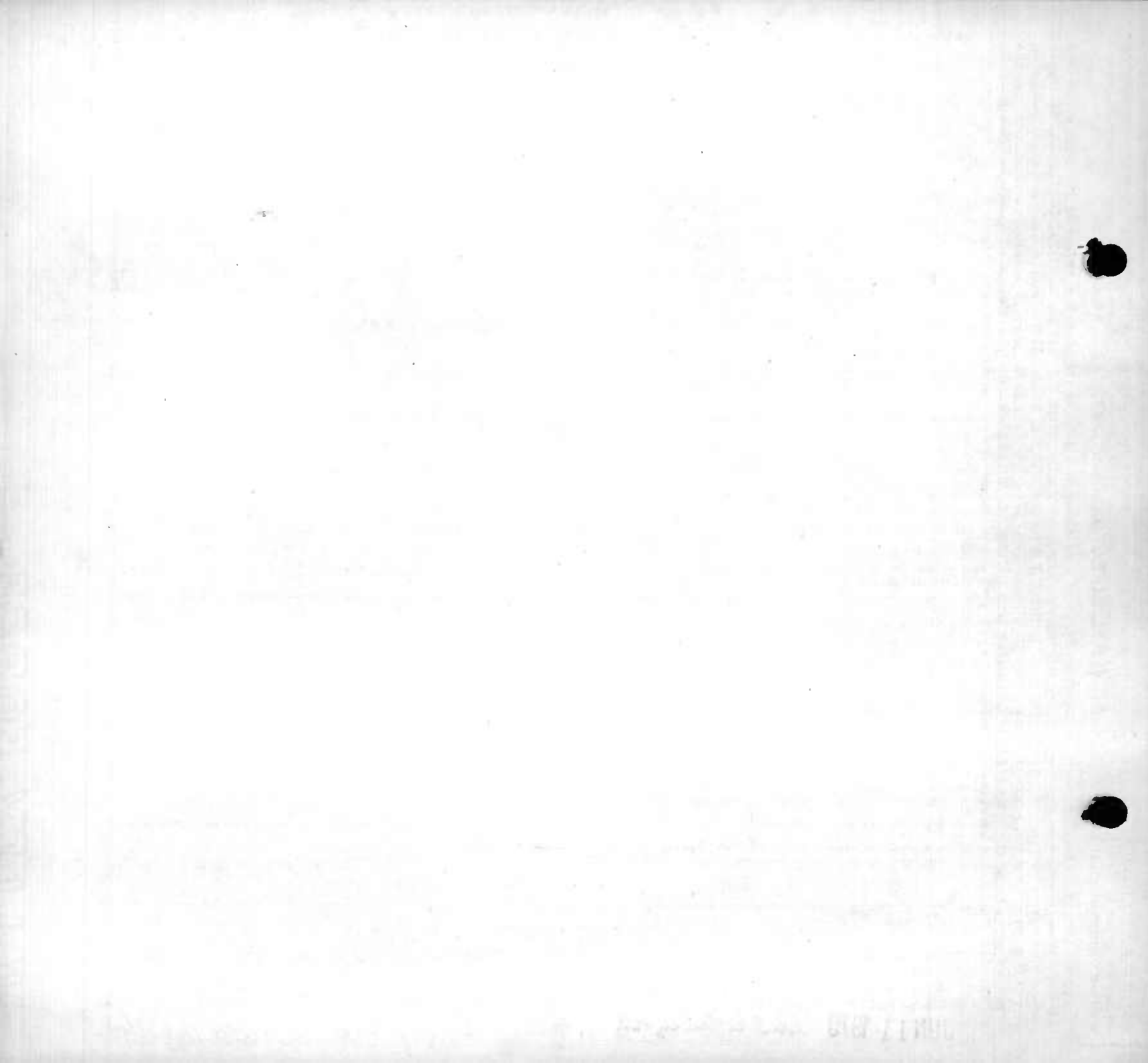
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-420		70 5954		70 5954	
1. NAME OF DECEASED (Type or Print) <b>HENRIETTA MOALES</b>		2. DATE AND HOUR OF DEATH <b>6-6-70 15:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Key Circle Hospice</b> <b>1214 Eutaw Pl.</b> <b>Balta. Md. 21217</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>1603</b>	
5. SEX <b>Female</b>		6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		B. DATE OF BIRTH <b>12/14/22</b>	
13. FATHER'S NAME <b>John Moales</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		9. AGE (in years last birthday) <b>97</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-14-9649J1</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
18. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Circulatory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>104-25</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-8-70</b> to <b>6-6-70</b> that (I) (we) last saw the deceased alive on <b>6-6-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard R. Rigler</b>		23B. DATE SIGNED <b>6-6-70</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD R. RIGLER M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-12-70</b>		24C. NAME of CEMETERY or CREMATORY <b>MO. Auburn Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Elmer O. Wilson</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25D. ADDRESS <b>1000 Bunting Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 70 5955	
1. NAME OF DECEASED (Type or Print) <b>Benjaminne Shelton Williams</b>		2. DATE AND HOUR OF DEATH <b>June 9, 1970 3:15 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2819 Spelman Rd Baltimore, Md 21225</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2562</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2819 Spelman Road</b>			
5. SEX <b>male</b>	6. RACE <b>negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-8-1906</b>	9. AGE (In years last birthday) <b>64 yrs</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>3</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburg, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Benjaminne Williams</b>		14. MOTHER'S MAIDEN NAME <b>Onie Murry</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Williams, same</b>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Carcinoma of Lung</b> DUE TO (B) <b>Pneumonia</b> DUE TO (C) <b>Stenosis of Oesophagus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>2 days</b> <b>6 wks.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1970</b> to <b>June 9, 1970</b> , that (I) (we) last saw the deceased alive on <b>June 8, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Jerry C. Luck</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>June 9, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jerry C. Luck</b>		23D. ADDRESS <b>427 Swale Rd. Balto, Md 21225</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-11-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Nat. Cem.</b>	
24D. LOCATION <b>Baltimore</b>		24E. LOCATION <b>md.</b>		24F. LOCATION <b>md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber, Jr.</b>		25C. FUNERAL DIRECTOR <b>Elmer G. Wilson</b>	
25D. ADDRESS <b>1000 Brantley Ave.</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 70 5956	
G-655 70 5956		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>MARIA GRINENKO</b> <b>MARIA GRINENKO</b>		2. DATE AND HOUR OF DEATH <b>6/9/70 3:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>MD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HOSPITAL</b> <b>43</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5406 BALLMAN AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/29/20</b>	9. AGE (in years last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>UKRAINE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alphonsus Hyllova</b> <b>ALPHONSUS HILL</b>			
14. MOTHER'S MAIDEN NAME <b>Frosia Sinkova</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>215-30-0627</b>		17. INFORMANT <b>Mr. John Grinenko, 5406 Ballman Ave.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CAUSE OF DEATH</b> <b>? Carcinoma of the uterus</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>2 Metastases to liver - ? elsewhere.</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6/8/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>6/8/70</b> 19 <b>70</b> to <b>JUNE 9</b> 19 <b>70</b> that (1) (we) last saw the deceased alive on <b>June 9</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Eric Sohn, M.D.</b>		23B. DATE SIGNED <b>6/9/70</b>		23C. PHYSICIAN'S NAME (Type) <b>Eric Sohn, M.D.</b>	
23D. ADDRESS <b>South Balto General Hospital</b>		23E. DATE <b>6/13/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. NAME OF CEMETERY OR CREMATORY <b>St. Andrew's</b>		24C. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>R-560</span> <span>70 5957</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>70 5957</span> </div>	
1. NAME OF DECEASED (Type or Print) <u>Thomas H. Rainier, SR.</u>		2. DATE AND HOUR OF DEATH <u>6-10-70</u> <u>7:05 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>49 North Charles Gen. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2302</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>32 E. Randall St. (21230)</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>49 North Charles Gen. Hosp.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1902</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Port Crane Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland Shipbuilding Dry dock</u>	9. AGE (in years last birthday) <u>68</u>
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amos Rainier (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bridges (deceased)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>812-05-2098</u>	
17. INFORMANT (Write) <u>and chart</u>		ADDRESS (Same) <u>Mrs. Field M. Rainier</u>	
18. <u>430X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Aspld; Pen. Mesenteric thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Aspld; Pen. Mesenteric thrombosis</u>			
19A. DATE OF OPERATION <u>6-10-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-21</u> 19 <u>70</u> to <u>6-10</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-10</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Rodelio M. Lim</u>		23B. DATE SIGNED <u>6-10-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>RODELIO M. LIM</u>		23D. ADDRESS <u>North Charles Gen. Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 13-1970</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Curtis E. Evans</u>		ADDRESS <u>1400 S. CHARLES ST 21230</u>	



35-2682 JD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

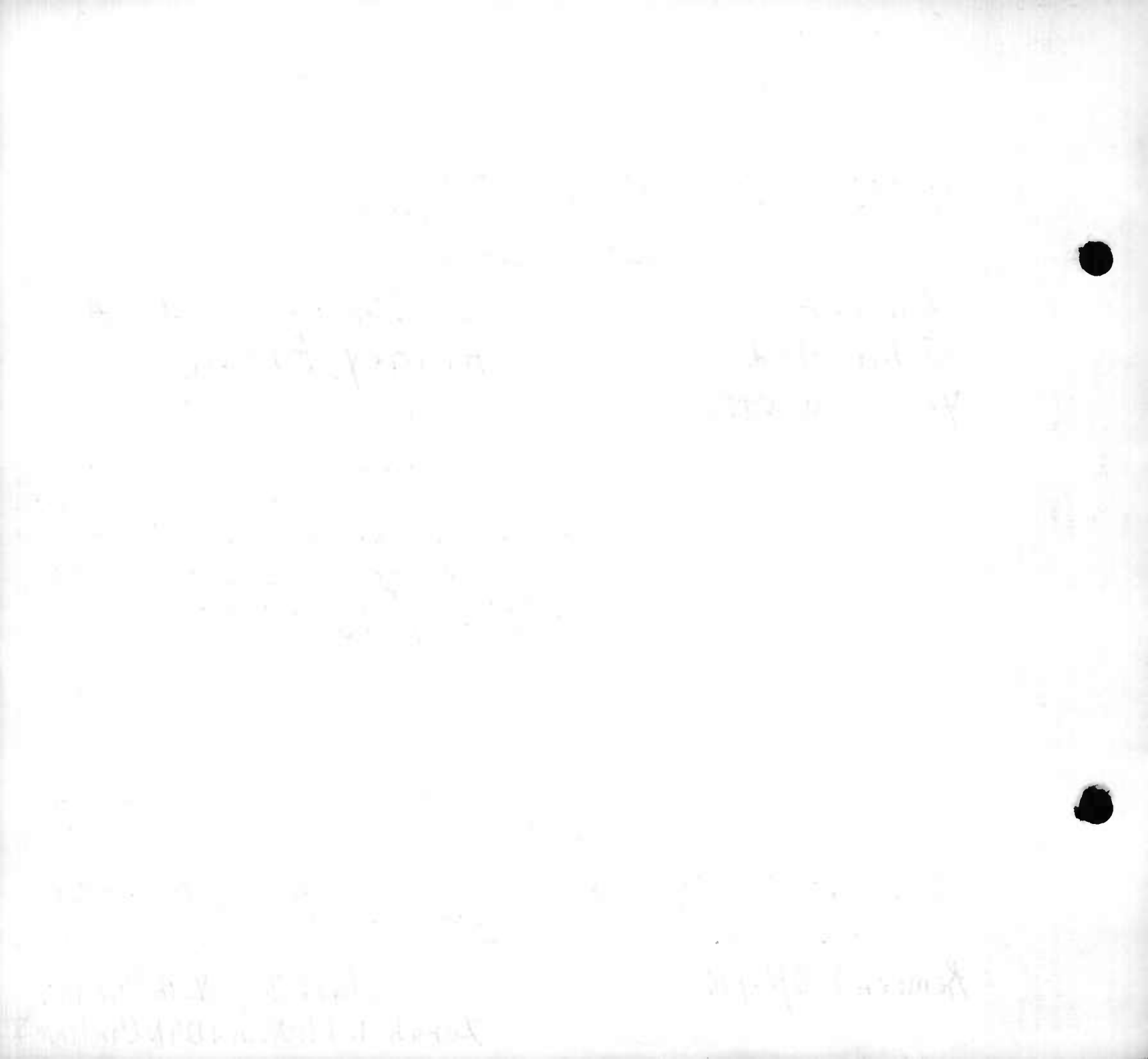
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-400 70 5958		CERTIFICATE OF DEATH		70 5958	
1. NAME OF DECEASED (Type or Print) <b>LEE VOGER HALL</b>			2. DATE AND HOUR OF DEATH <b>6-8-70 5:25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 Eastern Ave. BALTIMORE CITY HOSPITAL Baltimore, Md. 12224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>703</b> C. CITY OR TOWN <b>Baltimore, Md.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>810 N. Montford Ave. 21205 007</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-25</b>	9. AGE (In years last birthday) <b>45</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Schofield</b>		
14. MOTHER'S MAIDEN NAME <b>Roseann</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>212-34-8372</b>			17. INFORMANT <b>BCH Records: Baltimore, Md. 21224</b>		
18. <b>402 XI</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>MULTIPLE PULM. EMBOLI &amp; COR</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 2 yrs</b> <b>~ 2 yrs</b> <b>~ 20 yrs</b> <b>~ 1 yr.</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHRONIC RENAL FAILURE</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NEGATIVE</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (This hospital) attended the deceased from <b>3-23 1970</b> to <b>6-8 1970</b> that (1) (we) last saw the deceased alive on <b>6-8 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard K. Maza, M.D.</b>			23B. DATE SIGNED <b>6-8-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Richard K. Maza Md.</b>			23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/12/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Trinity Lutheran</b>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Farber, R.A.</b>	
24G. FUNERAL DIRECTOR <b>John G. Elchen 11297 Paulist.</b>		24H. ADDRESS		24I. VS 150-REV. 1/1/68	

on

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="font-size: 1.5em;">70 5959</span>	
BIRTH NO. <span style="font-size: 1.5em;">H-300 70 5959</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HOWARD E. HOOD</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">6-9-70</span> <span style="font-size: 1.5em;">1:50</span> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">BALTIMORE CITY HOSPITAL</span> 4940 Eastern Avenue Baltimore, Maryland			A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">808</span>		
5. SEX <span style="font-size: 1.2em;">Male</span>			6. RACE <span style="font-size: 1.2em;">Negro</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="font-size: 1.2em;">WIDOWED</span> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">S. Carolina</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">John Hood</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Arigey Brown</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes</span> <span style="font-size: 1.2em;">WWII</span>			16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">4940 Eastern Avenue</span> <span style="font-size: 1.2em;">Baltimore, Maryland 21224</span> BCH: Records
18. <span style="font-size: 1.2em;">410.91-019.0</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CELEBRAL ANOXIA</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">~ 5 days</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARDIORESPIRATORY ARREST</span> <span style="font-size: 1.2em;">~ 10 minutes</span> (B) <span style="font-size: 1.2em;">PROBABLE MYOCARDIAL INFARCT</span> <span style="font-size: 1.2em;">~ 5 days</span> (C) <span style="font-size: 1.2em;">ASPIRATION PNEUMONIA</span> <span style="font-size: 1.2em;">INACTIVE TUBERCULOSIS</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">Yes</span>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6-5</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6-9</span> 19 <span style="font-size: 1.2em;">70</span> that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6-9</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Richard K. Maza M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">6-9-70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Richard K. Maza M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">Baltimore City Hospitals</span> <span style="font-size: 1.2em;">4940 Eastern Avenue Baltimore, Maryland 21224</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Removal</span>		24B. DATE <span style="font-size: 1.2em;">6/12/70</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Charlotte, North Carolina</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JUN 11 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Zorah T. Ellickson-129 N. Caroline St.</span>	

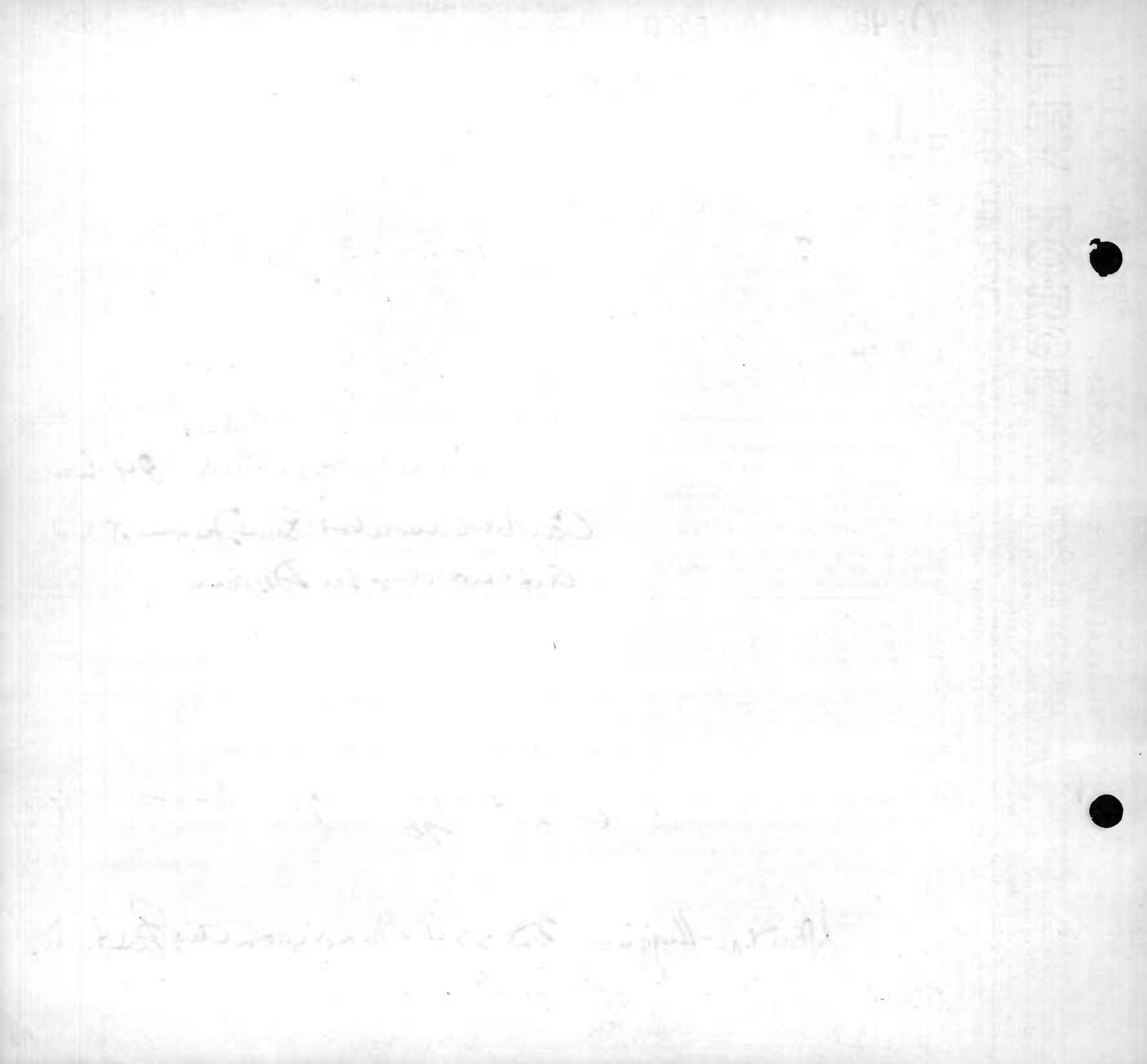




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-420		70 5960		70 5960	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Laddie Mills</i>			2. DATE AND HOUR OF DEATH <i>6/8/70</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2710</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>8222 Richwood Ave.</i>			C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>8222 Richwood Ave.</i>		
5. SEX <i>M.</i>	6. RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-03</i>	9. AGE (In years lost birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>retired</i>		11. BIRTHPLACE (State or foreign country) <i>D. C.</i>	
13. FATHER'S NAME <i>Thomas Mills</i>		14. MOTHER'S MAIDEN NAME <i>Ida Peake</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Dr. John B. Dean</i> ADDRESS <i>8145 Beach Dr. D.C.</i>	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-Vascular Disease</i> (C) <i>Arteriosclerotic Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 mos.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-27-1970</i> to <i>6-3-1970</i> , that (I) (we) last saw the deceased alive on <i>6-3-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Madaw Huggins</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Madaw Huggins</i>		23D. ADDRESS <i>2243 Madison Ave. Balt. Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/13/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1970</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph B. Lohs Jr.</i> ADDRESS <i>1304 N. Central</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

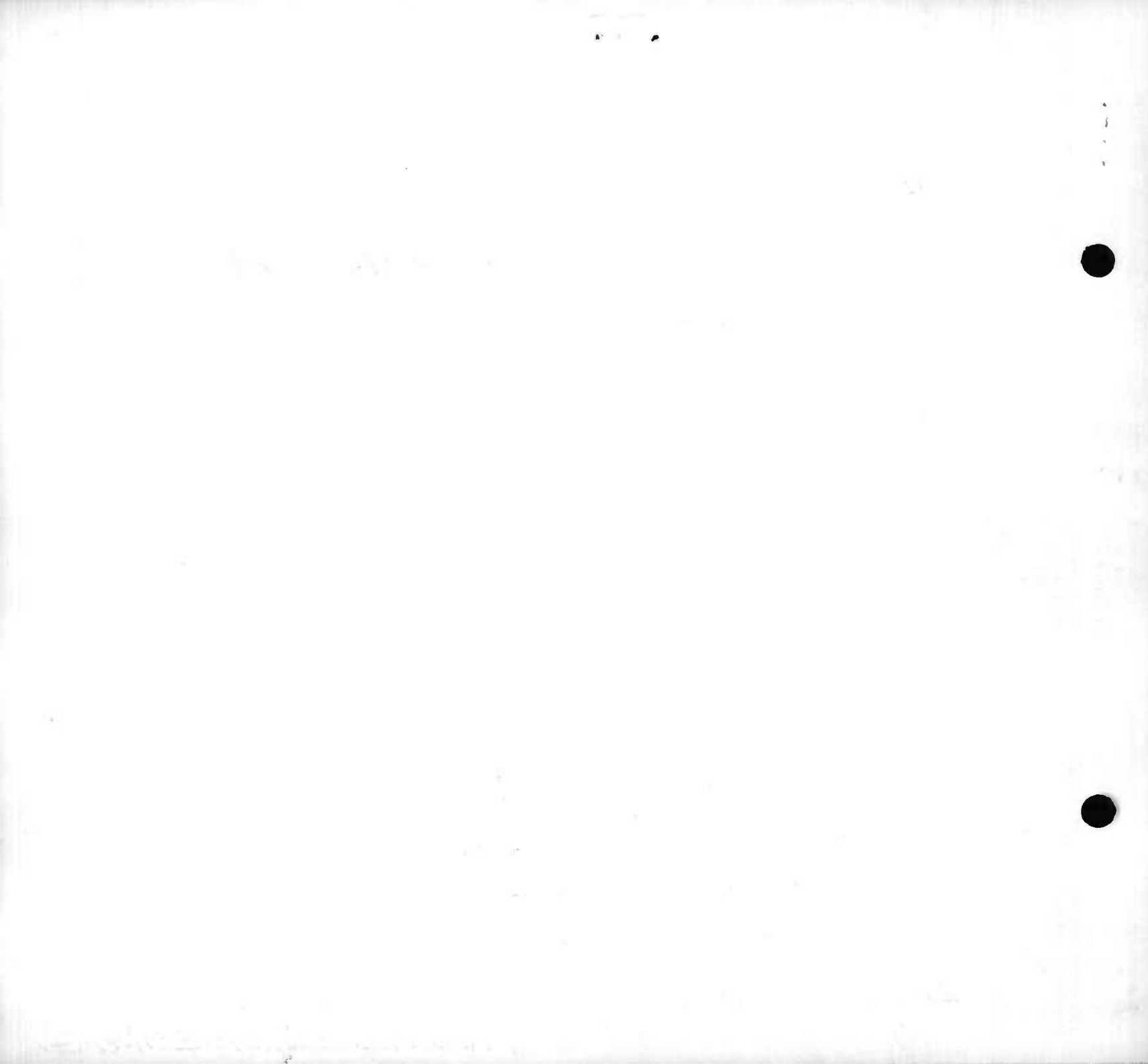
1. NAME OF DECEASED (Type or Print) a BESSIE CURTIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1231 E. Preston St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 8 1970 1:35 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1001	
9. DATE OF BIRTH		10. AGE (In years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Edward J. Foreman	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS 1231 E. Preston St.	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-8-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Liberty		24D. LOCATION (City, town, or county) (State) D.D. County - Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph B. Belk		ADDRESS 1304 N. Connelley	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 5962 CERTIFICATE OF DEATH					REG. NO. 70 5962				
1. NAME OF DECEASED (Type or Print) <b>JOHNSON ELENA N.</b>					2. DATE AND HOUR OF DEATH <b>June 9th, 1970 4:40 A.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNION MEMORIAL HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>906</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>					C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <b>1900 E. 31ST. STREET.</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02-20-1931</b>	9. AGE (in years last birthday) <b>49</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMTRESS</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Tailor Shop</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH F. NELSON</b>					14. MOTHER'S MAIDEN NAME <b>MARY E. HUGHES</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>342-2-6968</b>		17. INFORMANT <b>ELIZABETH FIELDS SAME AS ABOVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.3 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>CAUSE OF DEATH</b> <b>EXAMINER'S SIGNATURE</b> <b>CHIEF MEDICAL EXAMINER</b>					IMMEDIATE CAUSE <b>CEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 8th 1970</b> to <b>JUNE 9th 1970</b> that (I) (we) last saw the deceased alive on <b>JUNE 9th 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>J. Cabrera</b>					23B. DATE SIGNED <b>JUNE 9th, 1970</b>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>JUAN CABRERA</b>					23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6-12-70</b>		24C. NAME of CEMETERY or CREMATORY <b>National Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>			25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>			25C. FUNERAL DIRECTOR <b>Rudolph J. Collick</b>			
ADDRESS <b>2431 E. Oliver St.</b>									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-245 70 5963		BALTIMORE CITY HEALTH DEPARTMENT		70 5963	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOE McLENDON		2. DATE AND HOUR OF DEATH JUNE 7, 1970 9:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MD. B. COUNTY 908 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1110 E. NORTH AVE.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/10/10	9. AGE (In years last birthday) 59	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crain Operator		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Wadesboro NC.	
13. FATHER'S NAME John McLendon		14. MOTHER'S MAIDEN NAME Martha Dean		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 242-14-9538		17. INFORMANT Fannie R. McLendon 1110 E. North Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HODGKINS DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HODGKINS DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5/23 19 70 to 6/7 19 70 that (W) (we) last saw the deceased alive on 6/7 19 70 and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dennis W. Bleakley M.D.				23B. DATE SIGNED 6/7/70	
23C. PHYSICIAN'S NAME (Type) DENNIS W. BLEAKLEY		23D. ADDRESS M.D. DEGREE THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
24D. LOCATION Anne Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970			
25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR R. E. F. F.			
25D. ADDRESS 3431 E. Oliver St.					

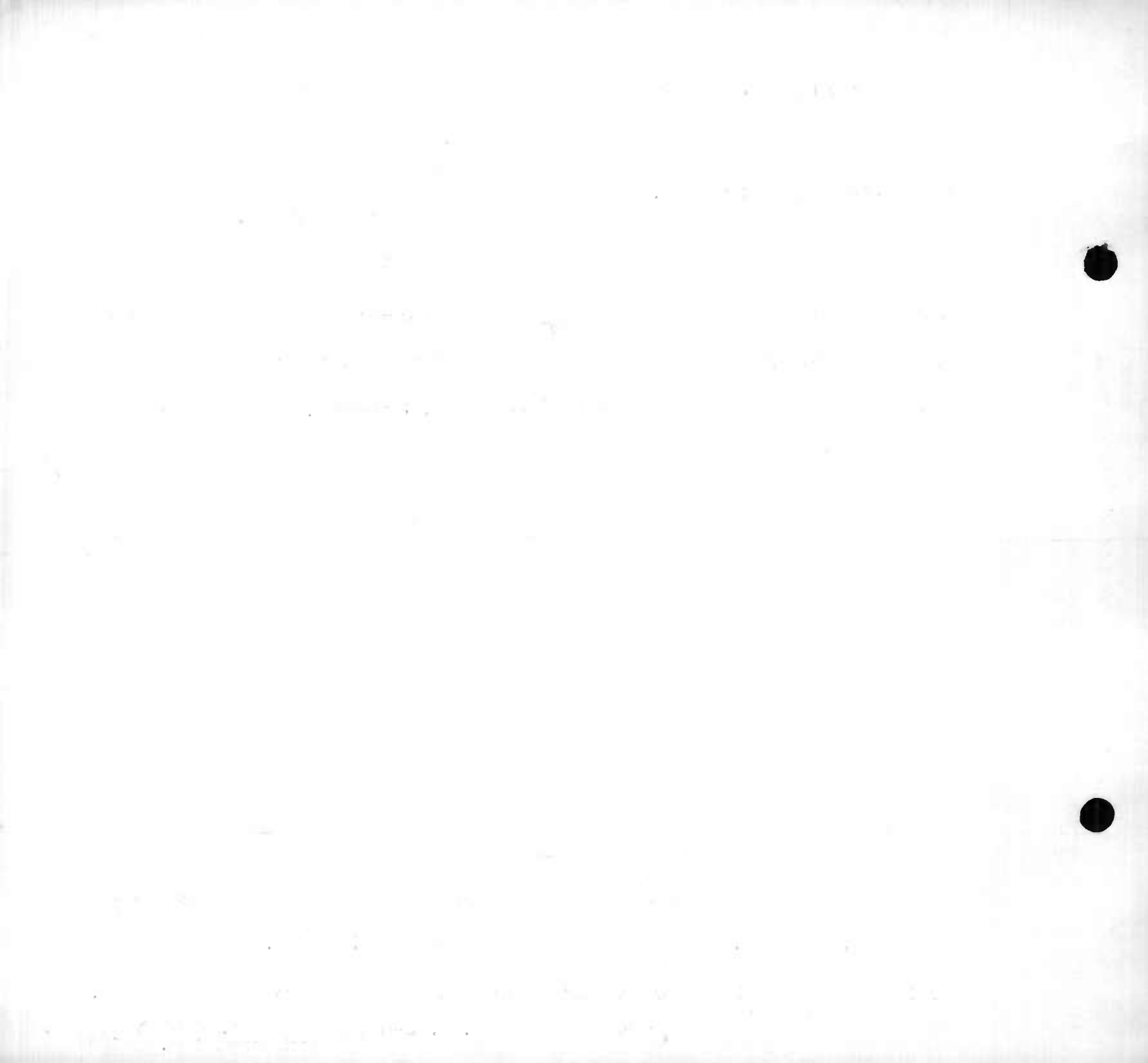




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

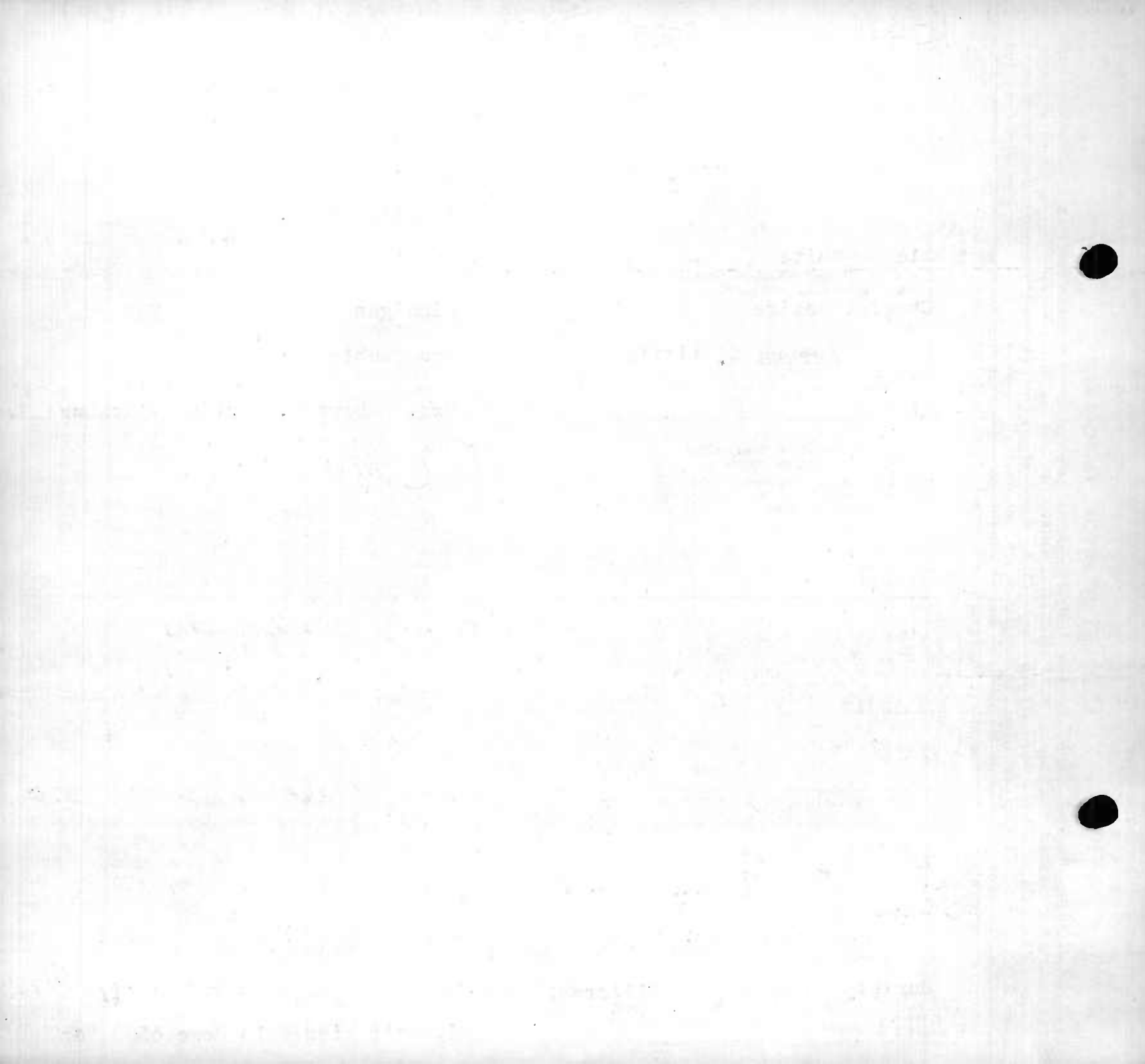
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5964</u>	
BIRTH NO. <u>H-623</u>		70 5964		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Pauline B. Horstman</u>			2. DATE AND HOUR OF DEATH <u>6-9-70</u> <u>12:30</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4419 Marble Hall Rd.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2759</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4419 Marble Hall Rd.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-1881</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Barth</u>			14. MOTHER'S MAIDEN NAME <u>Pauline Holzapfel</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-48-7277</u>	17. INFORMANT <u>Mrs. Henry R. Busch</u>		ADDRESS <u>Same</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease 10 yrs</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>January 1965</u> to <u>June 9 1970</u> that (I) <del>(we)</del> last saw the deceased alive on <u>June 8 1970</u> and that (in my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(not)</del> view the body after death.					
23A. SIGNATURE <u>A. Allan Spier</u>				23B. DATE SIGNED <u>6/11/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Allan A. Spier</u>		23D. ADDRESS <u>1501 Pentridge Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-12-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. LOCATION (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, R.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

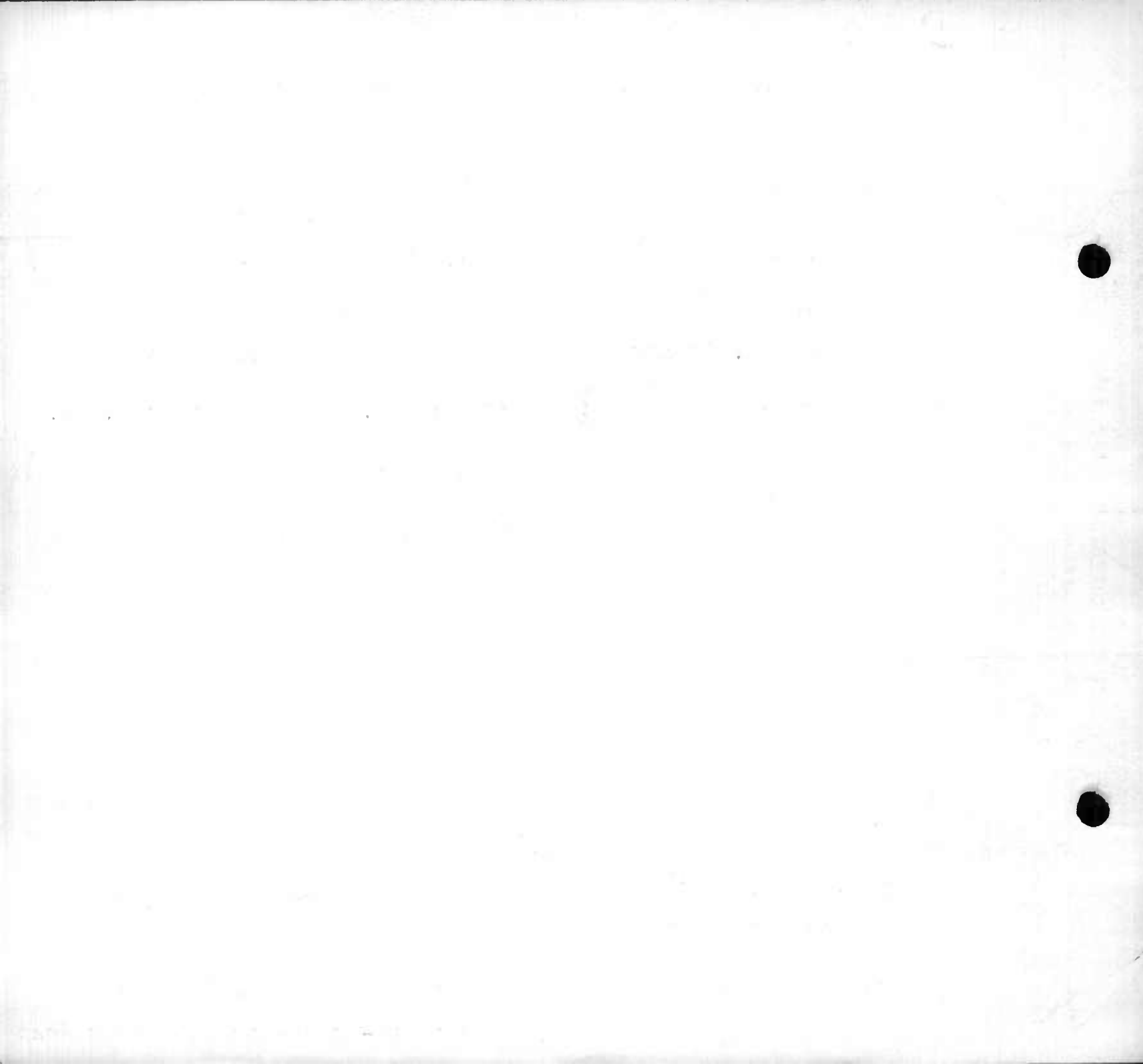
BIRTH NO. <b>L-340</b>		BALTIMORE CITY HEALTH DEPT. <b>70 5965</b>		CERTIFICATE OF DEATH <b>X</b>		REG. NO. <b>70 5965</b>	
1. NAME OF DECEASED (Type or Print) <b>Glenn A. Little</b>				2. DATE AND HOUR OF DEATH <b>6/2/1970 8:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6212 Blackburn Lane</b> <b>00</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Florida</b> B. COUNTY <b>V-08</b> C. CITY OR TOWN <b>West Palm Beach</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>131 Ellamar Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/95</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTHUR G. Little</b>				14. MOTHER'S MAIDEN NAME <b>Dora Fauble</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW1</b>		16. SOCIAL SECURITY NO. <b>220 20 7808</b>		17. INFORMANT <b>Mrs. Robert E. Martin</b>		ADDRESS <b>6212 Blackburn Lane</b>	
18. <b>160.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pulmonary Fibrosis Emphysema</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C. of Maxillary Sinus</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1964</b> to <b>6/2/1970</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Francis T. Daly, M.D.</b>				23B. DATE SIGNED <b>6/2/70</b>		23C. ADDRESS <b>11 East Chase Street 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/5/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hillcrest Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>West Palm Beach Florida</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell Wiedefeld Home 6500 York Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400 70 5966		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 5966	
1. NAME OF DECEASED (Type or Print) <b>DONALD R. DOOLEY</b>				2. DATE AND HOUR OF DEATH <b>JUNE 2<sup>ND</sup> 1970 9.00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				A. STATE <b>MD.</b>		B. COUNTY <b>2201</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>736, S. CHARLES STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/32</b>	9. AGE (In years last birthday) <b>37</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ROCKINGHAM CONSTRUCTION COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOWARD L. DOOLEY</b>				14. MOTHER'S MAIDEN NAME <b>MILDRED JULIA FRALIN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES KOREAN</b>		16. SOCIAL SECURITY NO. <b>223-38-6232</b>		17. INFORMANT (FATHER) ADDRESS <b>HOWARD L. DOOLEY VILLAMONT, VA.</b>			
18. CAUSE OF DEATH <b>5-21-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <b>CIRROSIS of Liver.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>② Ascitis, pleural effusion - months.</b> <b>③ Bronchopneumonia - weeks.</b> <b>④ Bleeding from oesophageal varices - weeks.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many yrs</b>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> 19 <b>70</b> to <b>6/2</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/2</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>DR. NANAVALI B. H.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/2/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. NANAVALI B. H.</b>				23D. ADDRESS <b>SOUTH BALTO. GEN. HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6/6/70</b>		24C. NAME of CEMETERY or CREMATORY <b>PRESBYTERIAN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>MONTVALE, VIRGINIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MITCHELL+WIEDEFELD 6500 YORK ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 5967</b>	
BIRTH NO. <b>B-653 70 5967</b>		1. NAME OF DECEASED (Type or Print) <b>SARA BURNET (SARA CURRIE BURNETT)</b>			
2. DATE AND HOUR OF DEATH <b>6/2/70 2:22 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>44 UNION MEMORIAL Hosp.</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>2712</b>		FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL Hosp.</b>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>308 E. LAKE AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/22</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Rhodes M. Currie</b>		14. MOTHER'S MAIDEN NAME <b>Hazel F. Fitzgerald</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>229-40-9848</b>		17. INFORMANT <b>Brother</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Complicating hypoglycemia, infection of burn wounds</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fractured L hip.</b>					
19A. DATE OF OPERATION <b>6/3/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured hip</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>308 E Lake Ave 2712</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1/5/70 A.M.</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell while going to bathroom</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> 19 <b>70</b> to <b>6/2</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/2</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>6/2/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>capt E. Foss</b>		23D. ADDRESS <b>UNION MEMORIAL Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>6/5/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		25D. ADDRESS <b>6500 York Rd. 21212</b>			

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Union Memorial Hosp.

F W

None

Rever. M. Curran

U S A



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5968</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Miss Alta Abbott</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>June 4, 1970 10:55 A.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Keswick Home for Incurables of Balto., City</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>1307</b>  <b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <b>700 W. 40th Street 21211</b>		
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-20-95</b>	<b>9. AGE</b> (In years lost birthday) <b>75</b>	<b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Belprie, Kansas</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Howard Briggs</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Louise Lampman</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-52-0763</b>		<b>17. INFORMANT</b> <b>Keswick Files</b> <b>ADDRESS</b> <b>700 W. 40th St.</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>390.01 + 250.9</b> <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Septicemia</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Chronic pyelonephritis with uremia</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>48 hours</b> <b>3 years</b> <b>10 years</b>		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Congenital hip dislocation, bilat.</b> <b>Diabetes mellitus</b>			<b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (this hospital) attended the deceased from April 19 43 to 6/4/70 that (we) last saw the deceased alive on 6/4/70 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>W.B. Daniels, Jr. M.D.</b>				<b>23B. DATE SIGNED</b> <b>6/5/70</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>W.B. Daniels, Jr.</b>				<b>23D. ADDRESS</b> <b>Keswick, 700 W. 40th St. Baltimore 21211</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>6/6/70</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Loudon Park Cent. Grad. Rd Balto Md</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JUN 11 1970</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Seiber, R.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Mitchell-Wiedefeld Home 6500 70th Rd</b>	

IN RESWICK SINCE 1943.

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70 5969 BALTIMORE CITY HEALTH DEPARTMENT

S-562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 5969

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dr FRANK SINNREICH		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year June 7 1970 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 7 1970 12:05P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Feb. 27. 1920		10. AGE (In years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. DDS		14B. KIND OF BUSINESS OR INDUSTRY Univ. of Md.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) YES W.W.II		17. SOCIAL SECURITY NO. 220-18-6311	
18. INFORMANT Mrs. F. J. Sinnreich		ADDRESS 3501 St. Paul St	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/70	
24C. NAME OF CEMETERY or CREMATORY St. Anne's		24D. LOCATION (City, town, or county) (State) Fiskedale Mass	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd.	

VS 151-REV. 7/1/68

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*Handwritten signature*

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

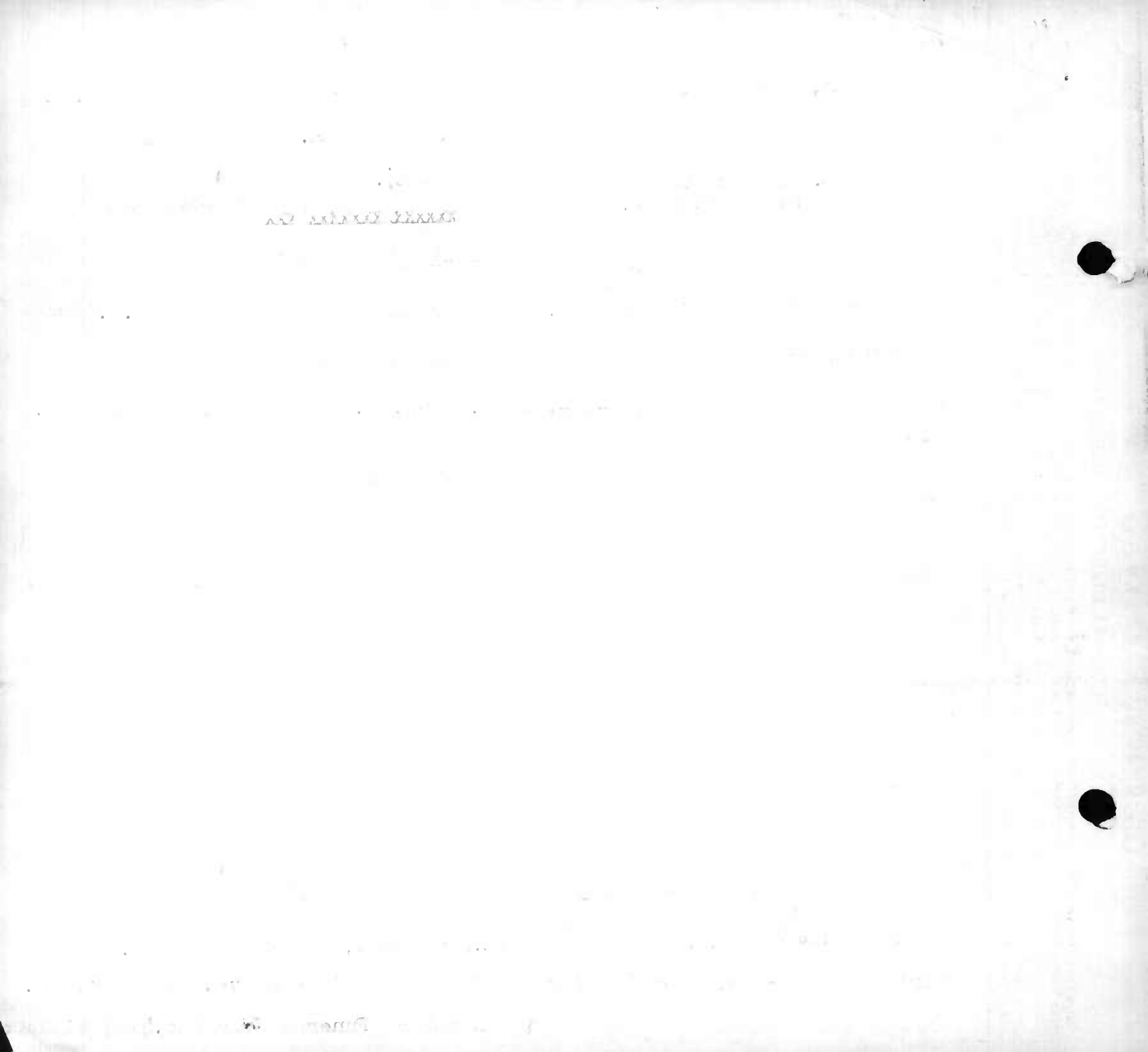
<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">70 5970</span>	
1. NAME OF DECEASED (Type or Print) <b>HAMMOND ALBERT. L.</b>		2. DATE AND HOUR OF DEATH <b>June 5, 1970. 8:40 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University of Maryland Hospital. Baltimore, Md. 21201.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <b>Maryland.</b> B. COUNTY <b>Baltimore.</b> C. CITY OR TOWN <b>Baltimore.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2315 Maryland Ave. Balto. Md. 21218.</b>	
5. SEX <b>Male</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/92</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor Johns Hopkins</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>ORHOND W. HAMMOND.</b>		14. MOTHER'S MAIDEN NAME <b>A DELAIDE MARTIN.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-22-4825</b>	
17. INFORMANT <b>MRS. A. L. HAMMOND</b>		ADDRESS <b>2315 MARYLAND AV</b>	
18. <b>15879 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal Obstruction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bacilleraemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>5/28/70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>rectal cancer</b>	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/17</b> 19 <b>70</b> to <b>6/5</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>6/5</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Thanasophon</b>		23B. DATE SIGNED <b>6/5/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>SORRYAN THANASOPHON.</b>		23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>6/9/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	24D. LOCATION (City, town, or county) (State) <b>MARYLAND, BALTO.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME</b>		ADDRESS <b>6500 YORK RD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital- and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5971</u>	
L-3200 5971		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Lutz, George J.</u>			2. DATE AND HOUR OF DEATH <u>6/8/70</u> <u>7:35P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 St. Agnes Hospital</u> <u>Wilkins &amp; Caton Ave.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>M</u>			6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <u>2-5-1885</u>			9. AGE (in years last birthday) <u>85</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Transit Co.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>George Lutz</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Jones</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>213-10-0516</u>		
17. INFORMANT <u>A. Mrs. C. Cavey</u>			ADDRESS <u>355 Martingale Ave.</u>		
18. <u>441.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Possible Rupture of abd. aortic aneurysm.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ching Hui Tsai, M.D.</u>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Ching Hui Tsai, M.D.</u>
23D. ADDRESS <u>St. Agnes Hosp., Wilkins &amp; Caton Ave.</u>			23E. DATE SIGNED		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-11-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Wilkins Ave. Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24G. FUNERAL DIRECTOR <u>H. Hubbard Funeral Home Inc.</u>		24H. ADDRESS <u>4107 Wilken</u>		24I. DATE SIGNED	

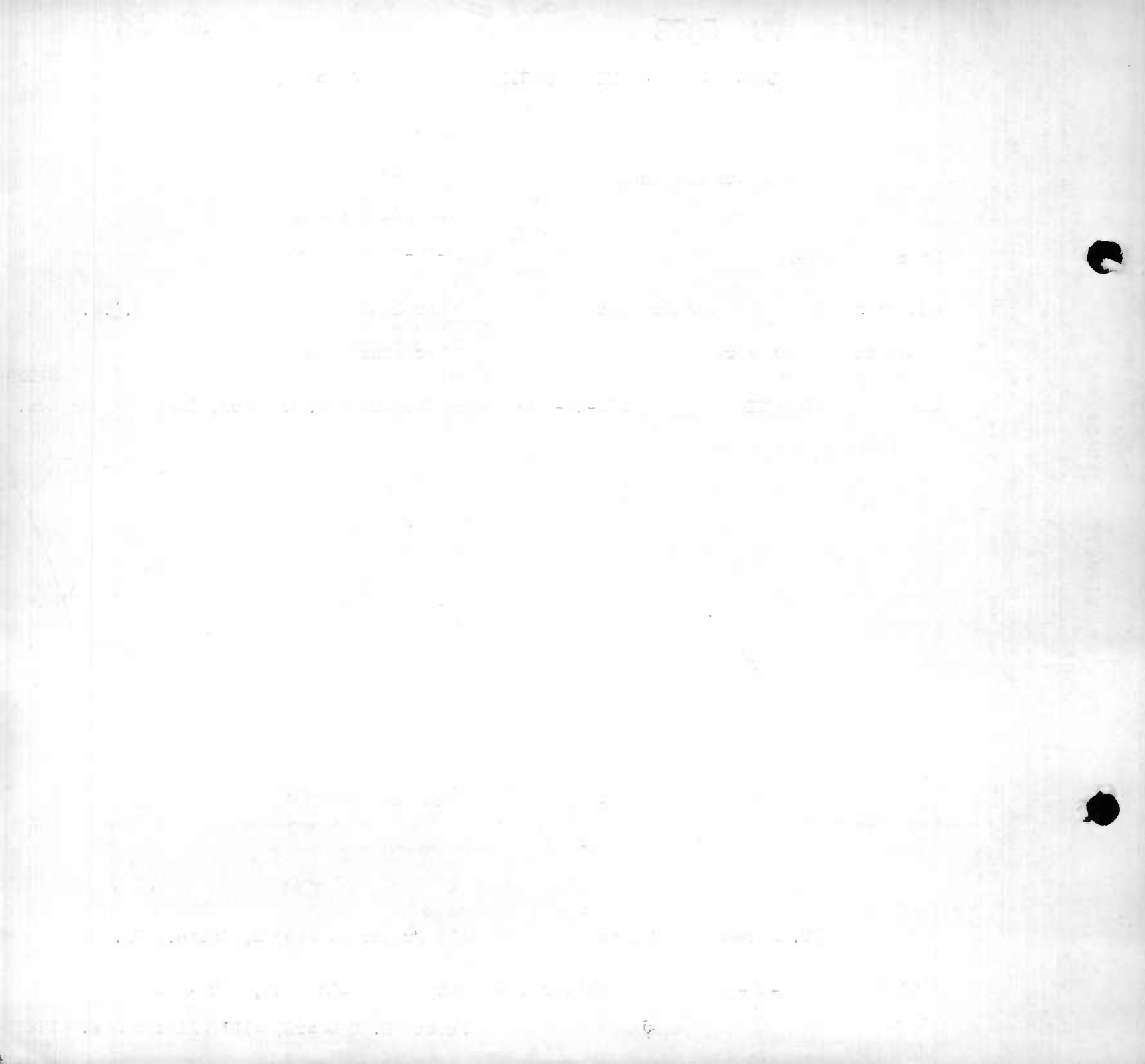




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 5972</b>	
M-260 70 5972		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>CIARENCE MARTIN MAGUIRE</b>		<b>June 8, 1970</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>Bon Secours Hospital</b>			A. STATE <b>Maryland</b>		
			B. COUNTY <b>1903</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1739 Wilkens Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-12-1907</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rate Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bealls Express</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Andrew Maguire</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Dee</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>		16. SOCIAL SECURITY NO. <b>215-09-4728</b>		17. INFORMANT <b>Miss Catherine C. Maguire, 1739 Wilkens Ave.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Occlusion</b> (B) <b>C.V. Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>over 7 or 8 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1953</b> to <b>May 1970</b> , that (I) (we) last saw the deceased alive on <b>May 16, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham Goldman, M.D.</b>				23B. DATE SIGNED <b>6/9/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Abraham Goldman</b>				23D. ADDRESS <b>4123 Frederick Avenue, Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-12-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 11 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 5973</u>	
Z-220 70 5973 BIRTH NO. <u>70-09409</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ZUKOWSKI</u>		2. DATE AND HOUR OF DEATH <u>JUNE 9, 1970</u> <u>12:30P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>40 ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>4322 BARRINGTON RD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7, 1970</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NEWBORN</u>	9. AGE (In years last birthday) <u>2</u> 11 Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL S. ZUKOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR REHER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Paul S. Zukowski, 4322 Barrington Rd.</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HYALINE MEMBRANE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DISEASE</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>JUNE 7 1970</u> to <u>JUNE 9 1970</u> that (2) (we) last saw the deceased alive on <u>JUNE 9, 1970</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J. Garcia</u>		23B. DATE SIGNED <u>6-9-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>LORCE GARCIA</u>		23D. ADDRESS <u>ST AGNES HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-10-1970</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		25D. ADDRESS <u>4107 Wilkens Ave. 21229</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5974	
BIRTH NO. 70 5974		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MOHLER, ALMA IRENE		2. DATE AND HOUR OF DEATH JUNE 9, 1970 1:30A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard Co. 21227 63-00 C. CITY OR TOWN ELKBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1803 MONTGOMERY RD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 23 97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALFRED BUSCHER			
14. MOTHER'S MAIDEN NAME MARGUERETTE (MULLEN)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none		17. INFORMANT AVER. BALTIMORE, MD. 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 154.1 I Ca of Rectum Metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MAY 30 19 70 to JUNE 9 1970 that (X) (we) last saw the deceased alive on JUNE 9 19 70 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dXXX) view the body after death.					
23A. SIGNATURE Chapman Tsai		23B. DATE SIGNED 06 09 70		23C. PHYSICIAN'S NAME (Type) P. Hing Hui Tsai, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) Howard Co.		24E. STATE (State) Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1970	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. Hubbard Funeral Home		25D. ADDRESS 4107 Wilkens	

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1944, 1945, 1946

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5975</span>	
C-565 70 5975				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		INA V. CAMERON		June 7, 1970 12:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  40 St. Agnes Hospital Wilkins & Caton Avenues				A. STATE Maryland	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 536 S. Smallwood Street	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1904	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Ben C. Putnan				14. MOTHER'S MAIDEN NAME Louisa A. Fishback	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-9283		17. INFORMANT Mr. Albert V. Cameron, 536 S. Smallwood St.	
18. <span style="font-size: 1.5em;">4589 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Hemorrhage Etiology indeterminate</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">ASCVD Cardiovascular</span> (C) <span style="font-size: 1.5em;">7</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">Diaphragmatic</span>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">6/7</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">6/7</span> 19 <span style="font-size: 1.5em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">6/7</span> 19 <span style="font-size: 1.5em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Earl I. Pass</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">6/8/70</span>	
23C. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass				23D. ADDRESS 4001 Wilkins Avenue, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-1970		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
				24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JUN 11 1970</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Fisher, JR.</span>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229	

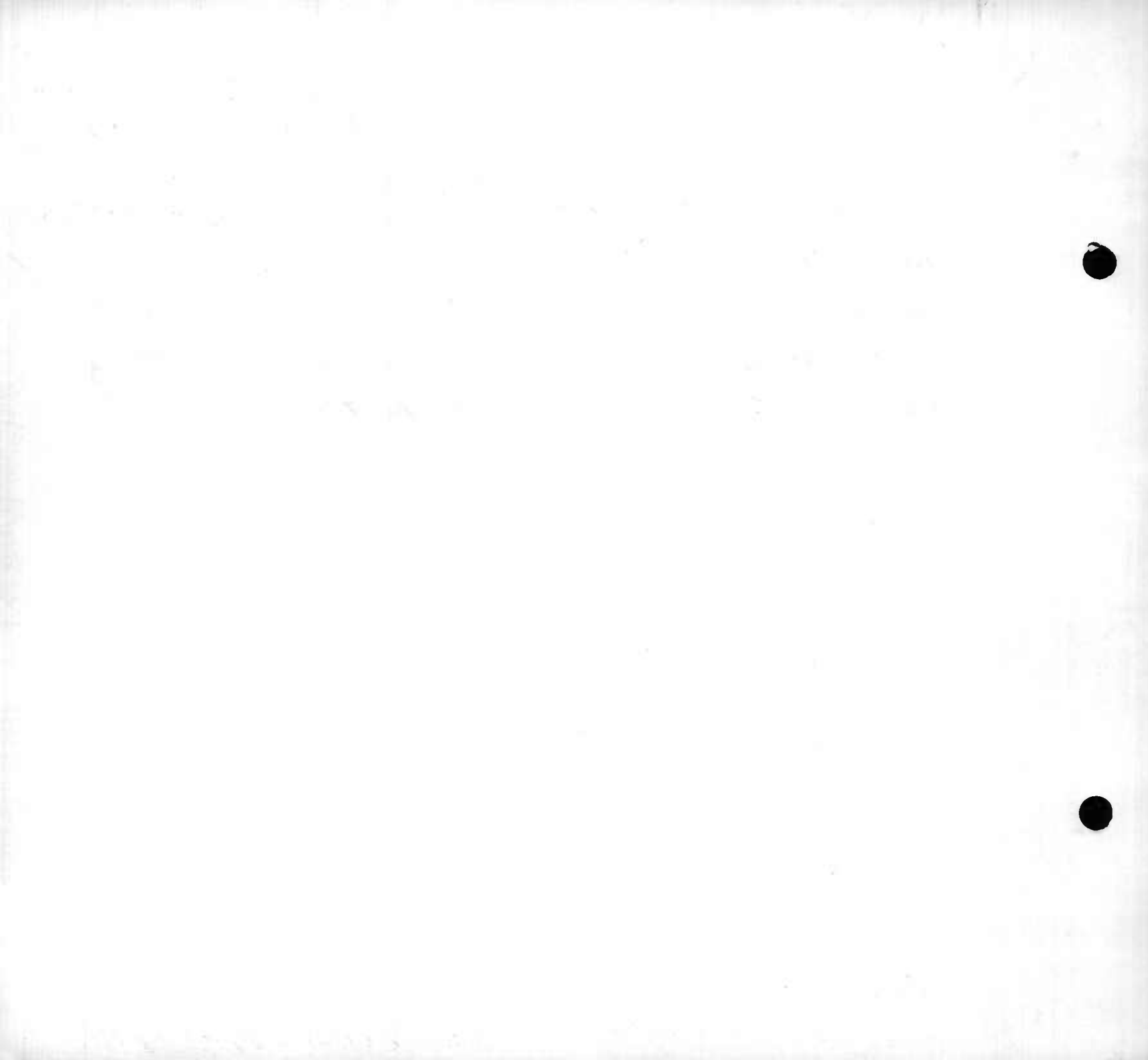
Dated of operation -



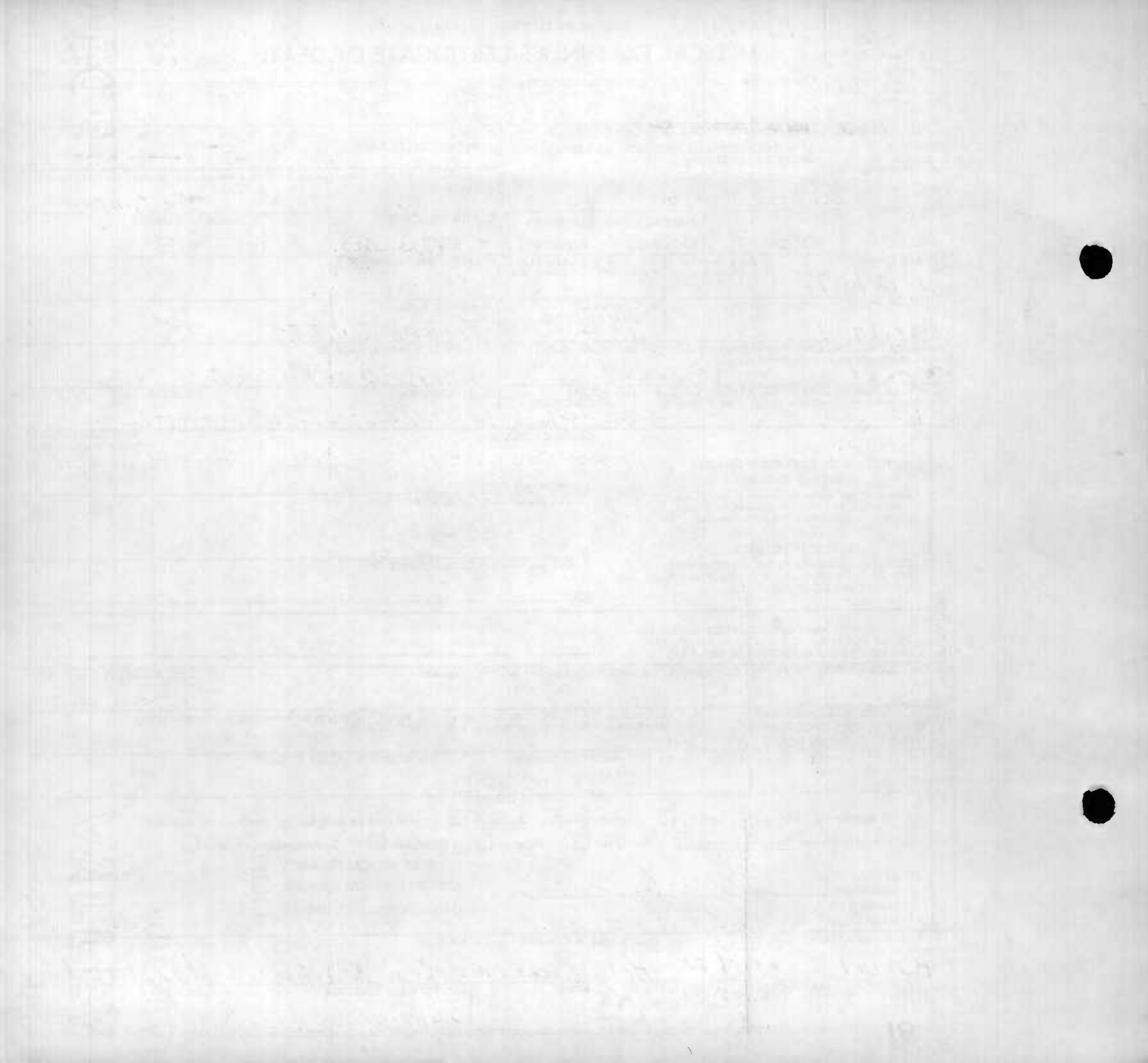
# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5976</span>	
CERTIFICATE OF DEATH					
<b>H-600</b> <b>BIRTH NO.</b> <span style="font-size: 1.5em;">70 5976</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.5em;">6/6/70</span> <span style="float: right;">2.10 P.M.</span>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MR. WILLIAM J. HERR.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2102</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">34 Bon Secours Hospital</span>		<b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>5. SEX</b> <span style="font-size: 1.5em;">M</span>		<b>6. RACE</b> <span style="font-size: 1.5em;">W</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">5-20-00</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">70</span>		<b>10. UNDER 1 Yr. Months Days</b> <b>Under 24 Hrs. Hours Min.</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Scaleman</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">"</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Herr</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Madeline Herr</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes W.W.I</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Hs. Chart</span>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">410.9 I</span>		<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">M.I.</span> DUE TO, OR AS A CONSEQUENCE OF:		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		<b>(B) ASCVD.</b> DUE TO, OR AS A CONSEQUENCE OF:			
<b>(C)</b>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/30</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">6/6/</span> 19 <span style="font-size: 1.2em;">70</span></b> <b>that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6/6</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Mayuree Khongcharoensuk, M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6/6/70.</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MAYUREE KHONGCHAROENSUK, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Bon Secours Hosp. Baltimore Md.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">6/10/70</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Baltimore National Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">JUN 11 1970</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Vabe B. E. Vabe, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Ambrose Fox 1329 S. Sulphur Sp Rd.</span>			



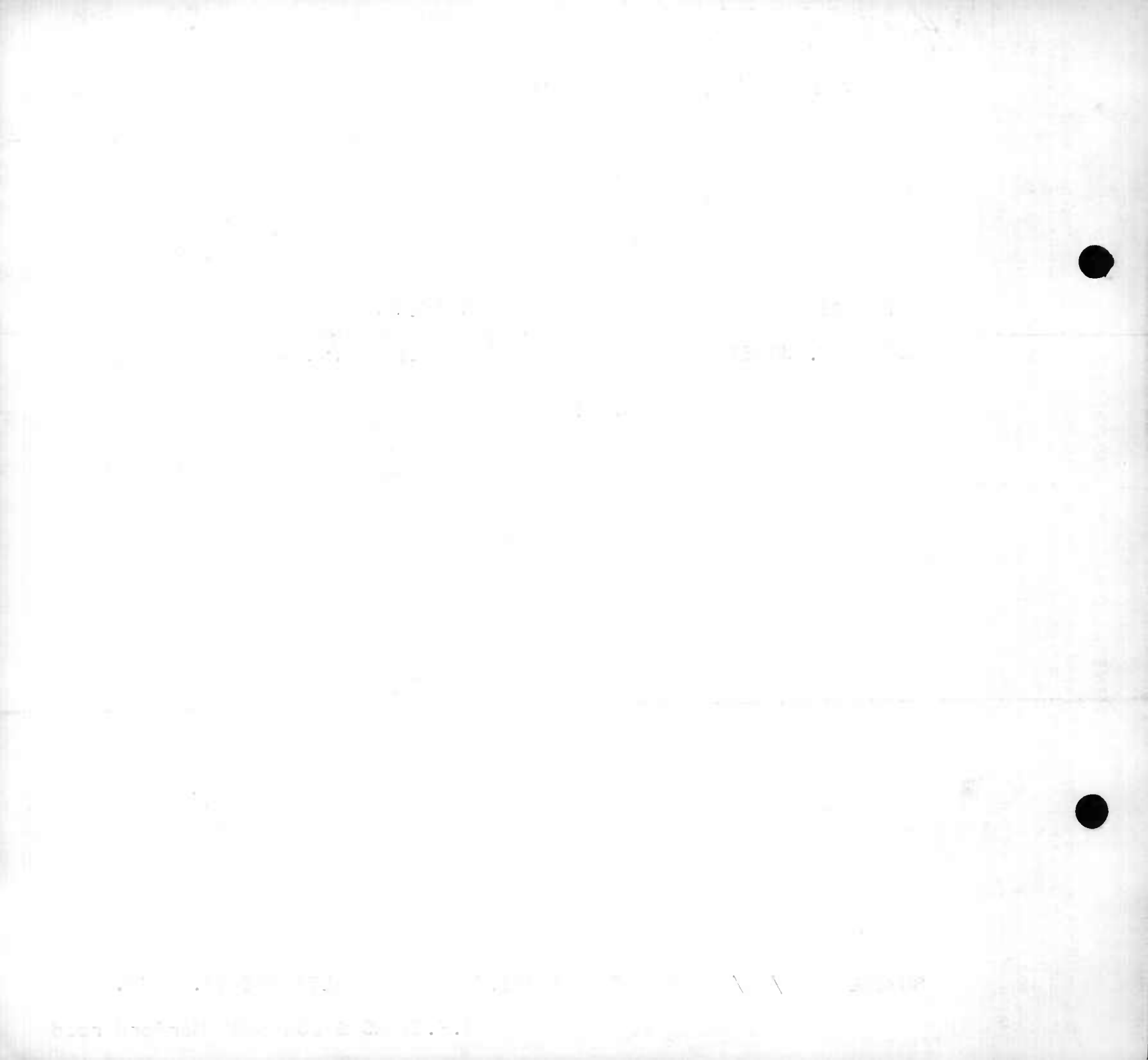
BIRTH NO.		70 5977		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 5977	
1. NAME OF DECEASED (Type or Print) <u>JOSEPH W. BUTTS, Sr.</u>					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 St. Agnes Hospital</u>					3. DATE PRONOUNCED DEAD Month Day Year Hour <u>6 7 1970 2:45 A.M.</u>				
6. SEX <u>Male</u>					7. RACE <u>White</u>				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					C. CITY OR TOWN <u>Arbutus Balto.</u>				
9. DATE OF BIRTH <u>11/12/07</u>					10. AGE (In years last birthday) <u>62</u>				
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Joseph Butts</u>					14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>				
15. MOTHER'S MAIDEN NAME <u>Mary Adlesberger</u>					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				
17. SOCIAL SECURITY NO. <u>212-28-9648</u>					18. INFORMANT <u>Dorothy Butts</u>				
19. CAUSE OF DEATH <u>412.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>disease</u>				
20A. DATE OF OPERATION <u>2</u>					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
21. AUTOPSY? (Yes or No) <u>yes (head)</u>									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> (head)				
22F. HOW DID INJURY OCCUR?									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Russell S. Fisher</u> EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED <u>6-8-70</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>6/10/70</u>				
24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Com.</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>					25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>				
25C. FUNERAL DIRECTOR <u>Ambrose Inc 1328 Sulphur Sp. Rd</u>					ADDRESS				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. <u>H-156</u>		70 5978		REG. NO. <u>70 5978</u>					
1. NAME OF DECEASED (Type or Print) <u>HAEFFNER, CHRISTINE</u>				2. DATE AND HOUR OF DEATH <u>June 9, 1970</u> <u>7:30 p.m.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Simon Hospital of Baltimore</u> <u>Baltimore, Md. 21215</u>				A. STATE <u>Baltimore</u>		B. COUNTY <u>3005 Woodside Ave. #34</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		NO <u>5300</u>	
E. STREET AND NUMBER <u>Maryland</u>									
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/26/93</u>		9. AGE (In years last birthday) <u>76</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARTHUR H. JONES</u>				14. MOTHER'S MAIDEN NAME <u>ADELIA MATHEWS</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Harry Haeffner, same</u>					
18. <u>3-75 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Cholecystitis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart Failure</u> (B) <u>Acute Cholecystitis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>5/31</u> 19 <u>70</u> to <u>6/9</u> 19 <u>70</u> . that (1) (we) last saw the deceased alive on <u>6/9</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Kantorn 901</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>KANTORN KRITAYAKRADA</u>				23D. ADDRESS <u>Simon Hospital of Baltimore</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/13/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>C.F. EVANS &amp; SON</u> 8802 Harford road					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 5979</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">GOLDIE KUNKEL</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">6/15/70</span> <span style="float: right; font-size: 1.2em;">7:40 A.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <span style="font-size: 1.2em;">MD. GEN HOSP</span> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">48</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALTO</span> C. CITY OR TOWN <span style="font-size: 1.2em;">OWINGS MILLS</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">R 2 DEER PARK RD</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">5/23/12</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">58</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">OSCAR REDMAN</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">HARRIETT FREE</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <span style="font-size: 1.2em;">?</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-16-5129</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">PATIENT-CHART</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">HEMORRHAGE</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">RUPTURED ABDOMINAL ANEURYSM 2 HRS</span> DUE TO, OR AS A CONSEQUENCE OF: (C)			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">6/15/70</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">RUPT. ANEURYSM</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		(If In Baltimore City, give exact location)			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <span style="font-size: 1.2em;">No</span>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">6/3/70</span> <b>19</b> <b>to</b> <span style="font-size: 1.2em;">6/15</span> <b>1970</b> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">6/5</span> <b>19</b> <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Donald B Hebb</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">6/15/70</span>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">DONALD B HEBB</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">111 W MONUMENT ST</span>			
<b>24A. BURIAL CREMATION REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b>	
<span style="font-size: 1.2em;">Burial June 8 1970</span>		<span style="font-size: 1.2em;">Lorraine Park</span>		<span style="font-size: 1.2em;">BALTO MD</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JUN 12 1970</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Frank A. Ximell, Baltimore</span>	

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# FUNERAL DIRECTOR: IMPORTANT

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S-565 70 5980		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5980	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>VINCENT JOSEPH SMERMAN</u>		2. DATE AND HOUR OF DEATH 6/7/70		8:30 am M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.		E. STREET AND NUMBER 4210 Colonial Road #21208		5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-92		9. AGE (In years last birthday) 77		If Under 1 Tr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY WEVERING COFFEE		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Smearman		14. MOTHER'S MAIDEN NAME Tresch		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 213-03-5371A	
17. INFORMANT Mrs. Barbara Smearman		ADDRESS Colonial Rd. Pkts. 4210		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years years	
19A. DATE OF OPERATION 2 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (E) (this hospital) attended the deceased from 5/21 1970 to 6/7 1970 that (E) (we) last saw the deceased alive on 6/7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (E) (We) (did) (not) view the body after death.		23A. SIGNATURE Barb Bedo, M.D.	
23B. PHYSICIAN'S NAME (Type) BARBEDO M.D.		23C. ADDRESS MERCY HOSP.		23D. DATE SIGNED 6/7/70		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 11, 1970		24C. NAME OF CEMETERY OR CREMATORY Pine Lake View Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Frank J. Howell		25D. ADDRESS Baltimore, Md.	

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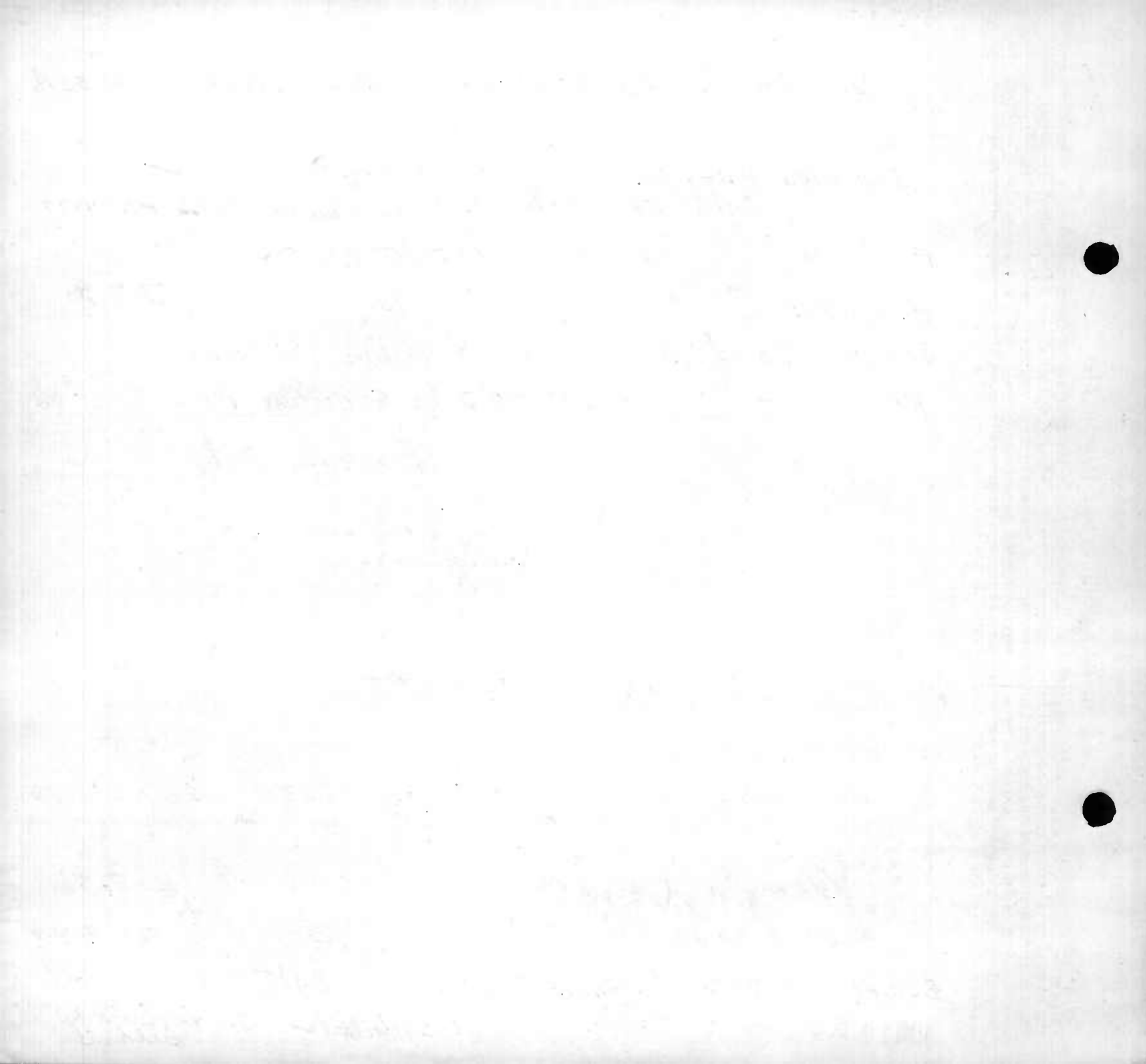
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Handwritten text, possibly a date or reference number.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 5981		REG. NO. _____	
M-451		70 5981		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>VIRGINIA L. MULLENBERG</b>				2. DATE AND HOUR OF DEATH <b>JUNE 8, 1970 10:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>508 GLEN ALLAN DR 00 BALTO. MD 21229</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2834</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/21/1882</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <b>88</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>Joseph Douldiken</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-22-6794</b>		17. INFORMANT <b>JULIA G. HOFFMAN</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Vascular disease</b> (B) <b>Coronary artery sclerosis + insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-30-1963</b> to <b>6-8-1970</b> , that (I) (we) last saw the deceased alive on <b>6-6-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Karry R. Knipp, MD</b>				23B. DATE SIGNED <b>6-9-70</b>		23C. PHYSICIAN'S NAME (Type) <b>KARRY R. KNIPP, MD.</b>	
23D. ADDRESS <b>4116 EDMONDSON AV. BALTIMORE, MD 21229</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>6/9/70</b>				24C. NAME OF CEMETERY OR CREMATORY <b>LORRAINE CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>E. S. MacNell</b>	
						ADDRESS <b>301 Frederick Rd BALTO MD</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**CERTIFICATE AMENDED - 7/14/70**  
North Charles Gen. Hosp.

N-600		BALTIMORE CITY HEALTH DEPARTMENT		70 5982	
BIRTH NO. 70 5982		CERTIFICATE OF DEATH		REG. NO. 70 5982	
1. NAME OF DECEASED (Type or Print) <b>BESSIE NEWER</b>			2. DATE AND HOUR OF DEATH <b>6-9-70 1:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Baltimore Co</b> B. COUNTY <b>5300</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>North Charles Gen. Hosp.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3522 Langreh v</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-04</b>	9. AGE (in years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>(Morris) Israel Davison</b>			14. MOTHER'S MAIDEN NAME <b>Sena Volmer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>085-32-9263</b>		17. INFORMANT <b>Chant</b>
18. <b>250.0 H-162.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes</b> <b>Diabetes mellitus</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ca of the lung</b>					
19A. DATE OF OPERATION <b>6-9-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-9-70</b> to <b>6-9-70</b> that (I) (we) last saw the deceased alive on <b>6-9-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rodelio M. Lim</b>			23B. DATE SIGNED <b>6-9-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>RODELIO M. LIM</b>			23D. ADDRESS <b>North Charles Gen. Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/12/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Moses Montrose</b>	
24D. LOCATION <b>Baltimore</b>		24E. NAME of REGISTRAR <b>Robert E. Taylor</b>		24F. FUNERAL DIRECTOR <b>Sylvester A. Son</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>		24H. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24I. ADDRESS <b>9610 Reisterstown Rd</b>	

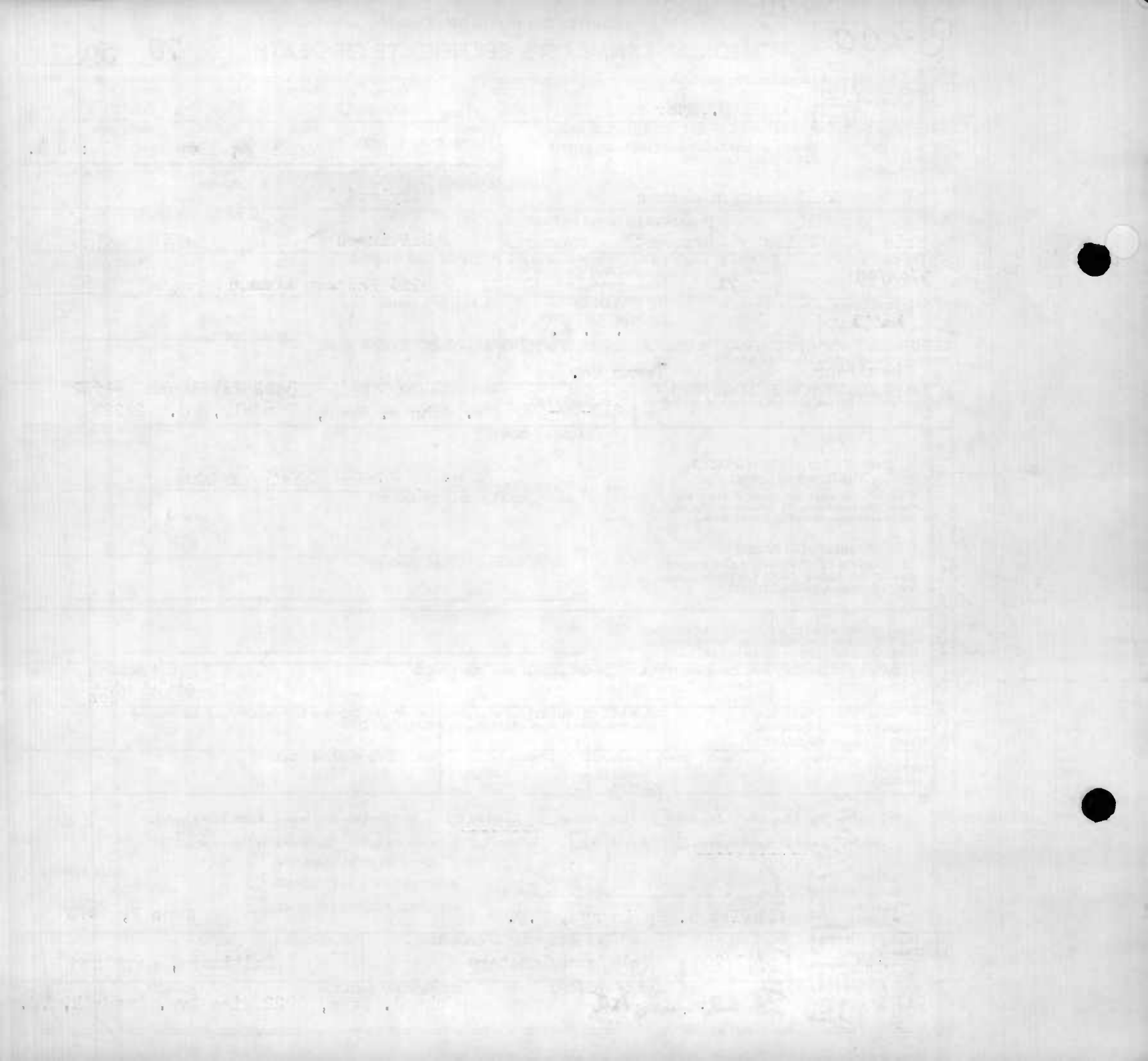
7/10/10 - Letter from North  
Charles General Hospital.  
Signed by Mrs. Anita Gilbert.

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5983

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN H. Byer		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2235 Eastern Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 9, 1970 10:40 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/25/99		10. AGE (In years lost birthday) 71	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-09-5846	
18. INFORMANT (Son) Mr. John A. Byer, 3402 Yardley Drive, Dundalk, Md. 21222		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2/2/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: June 9, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/70	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

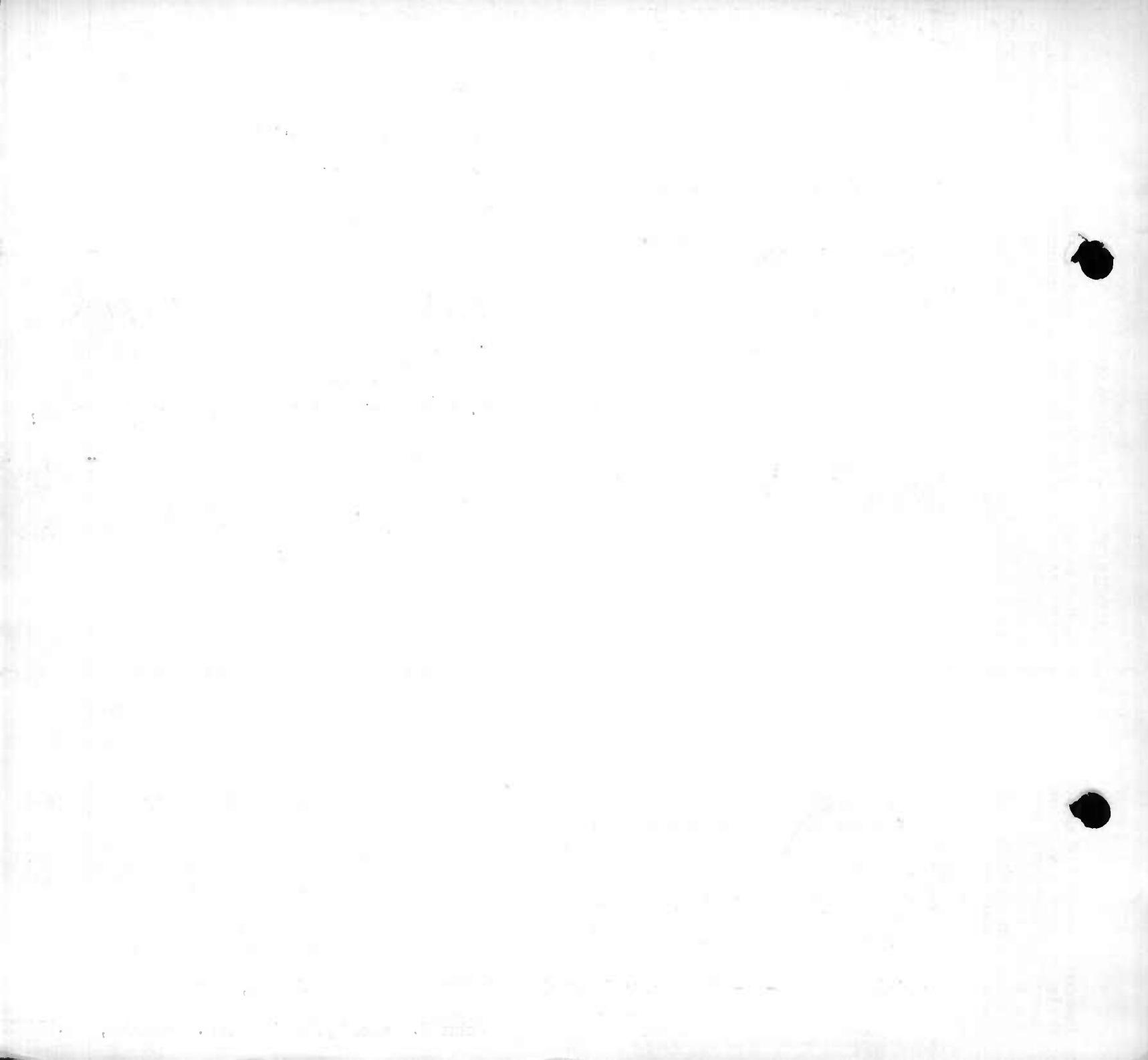




# FUNERAL DIRECTOR: IMPORTANT


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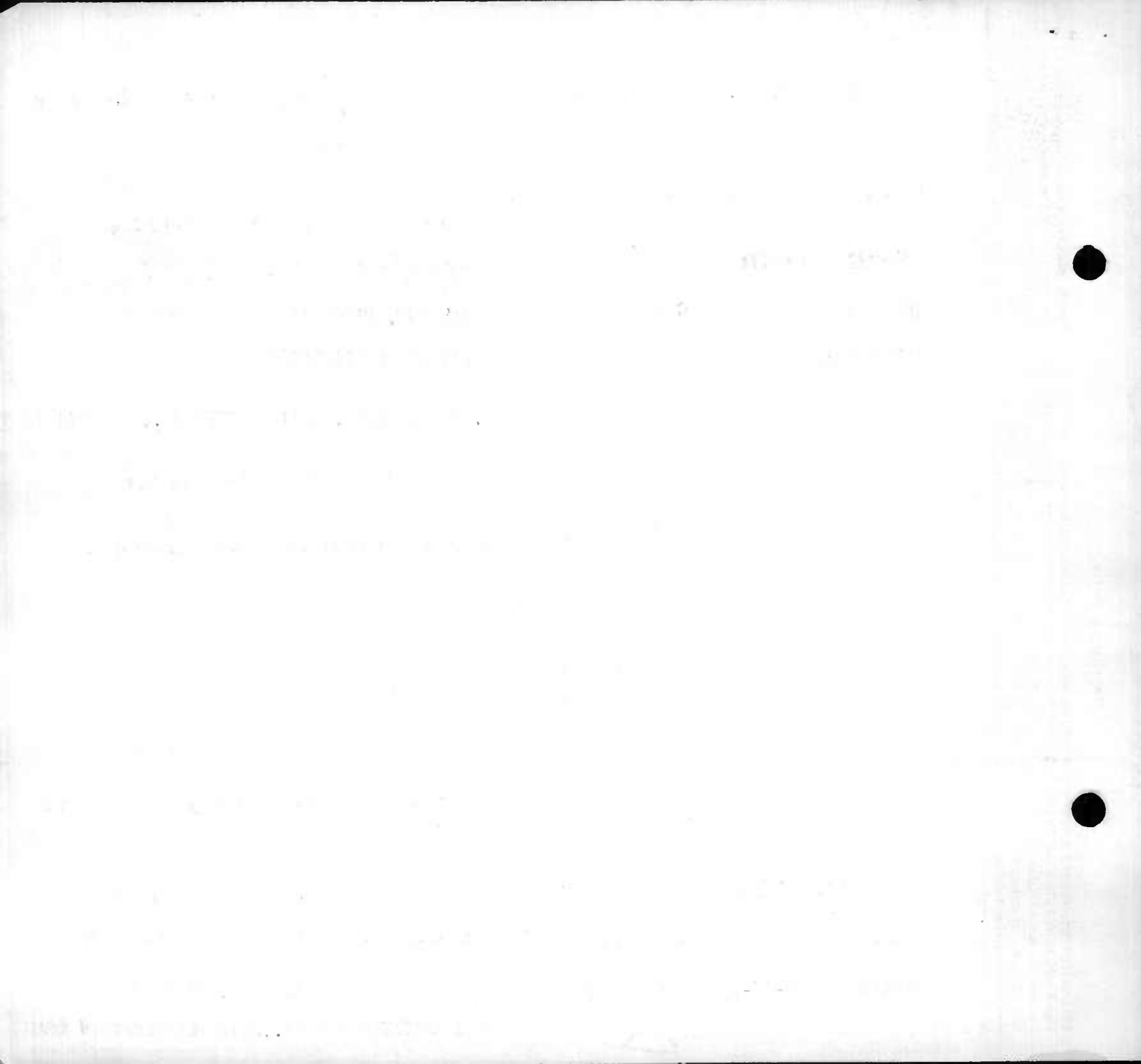
I-525		70 5984		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 5984			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MRS. FRANCES C. INSINGA</b>				2. DATE AND HOUR OF DEATH <b>JUNE 9, 1970 8:05 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>				5. SEX <b>Female</b> 6. RACE <b>White</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? <b>BALTIMORE</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2913 CORNWALL ROAD</b>				8. DATE OF BIRTH <b>8-14-14</b>				9. AGE (in years last birthday) <b>55</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>				13. FATHER'S NAME <b>FRANK SENATO</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES GRANDOLFO</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>				17. INFORMANT (Husband) ADDRESS <b>Mr. Paul Insinga 2913 Cornwall Road Dundalk, Md.</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION 5 days?</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease - Years.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days?</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>No</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>June 3</b> 19 <b>70</b> to <b>June 9</b> 19 <b>70</b> that <del>we</del> (we) last saw the deceased alive on <b>June 8</b> 19 <b>70</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Cesar A. Lopez MD</b>				23B. DATE SIGNED <b>June 9, 1970</b>							
23C. PHYSICIAN'S NAME (Type) <b>CEZAR A. LOPEZ MD</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSP.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>6-13-70</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>			
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>				25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md. 21222</b>			



**FUNERAL DIRECTOR: IMPORTANT**

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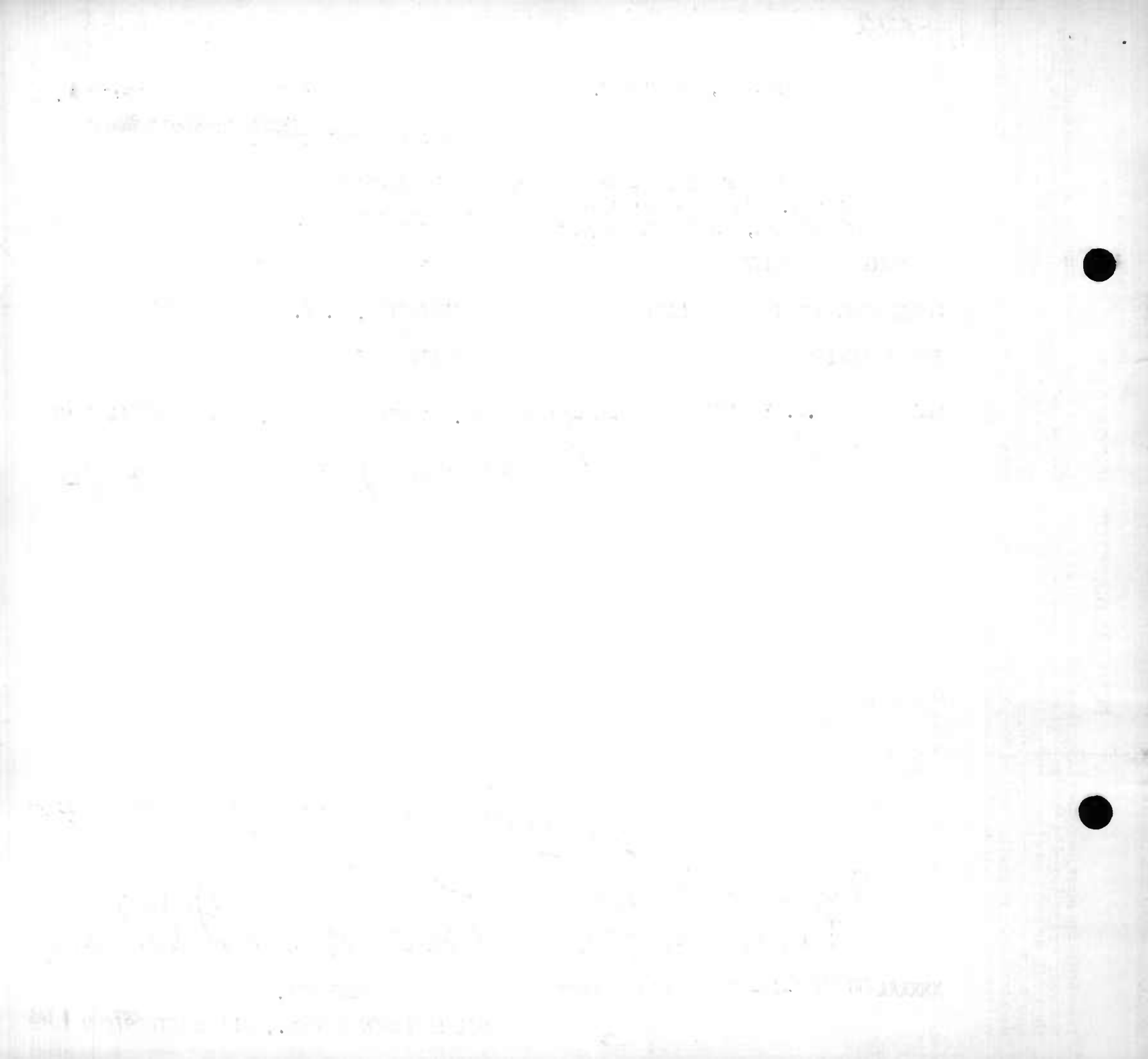
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5985</u>	
D-120 70 5985		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>DAVIS, M. KATHERINE</b>		2. DATE AND HOUR OF DEATH <b>6 / 9 / 1970 4.50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b> <b>42</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>RANDALLSTOWN</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3911 Chaffey Rd. 21133.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/07</b>	9. AGE (in years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RICHMOND, VIRGINIA</b>	
13. FATHER'S NAME <b>MOSES FALK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>A. JESSE DAVID, 3911 CHAFFEY RD., RANDALLSTOWN</b>	
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>SUBARACHNOID HAEMORRHAGE.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/7/1970</b> to <b>6/9/1970</b> that (I) (we) last saw the deceased alive on <b>6/9/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>6/9/1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANDREAS A. PETSAS</b>		23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-11-70</b>		24C. NAME of CEMETERY or CREMATORY <b>OHEB SHALOM</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 5986		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 5986	
1. NAME OF DECEASED (Type or Print) <b>HERZOG, MILTON J.</b>			2. DATE AND HOUR OF DEATH <b>6/9/70 10:15 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 HOUSE IN THE PINES - BELVEDERE 2525 W. BELVEDERE AVENUE BALTIMORE, MARYLAND 21215</b>			C. CITY OR TOWN <b>RANDALLSTOWN</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>9220 TURNBULL ROAD</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/87</b>	9. AGE (In years last birthday) <b>83</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PURCHASING AGENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOSEPH HERZOG</b>			14. MOTHER'S MAIDEN NAME <b>ROSALIE ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. I NAVY</b>		16. SOCIAL SECURITY NO. <b>38-03-1180A</b>	17. INFORMANT ADDRESS <b>MRS. HENRIETTA HERZOG, 9220 TURNBULL ROAD</b>		
18. CAUSE OF DEATH <b>1519 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of stomach</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>2 yrs</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 1967</b> to <b>June 9 1970</b> that (I) (we) last saw the deceased alive on <b>May 19 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin Sauber</b>			23B. DATE SIGNED <b>June 9, 1970</b>		
23C. PHYSICIAN'S NAME (Type) <b>IRVIN SAUBER</b>			23D. ADDRESS <b>6905 Park Heights Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL CREMATION</b>		24B. DATE <b>6-11-70</b>		24C. NAME of CEMETERY or CREMATORY <b>LOUDEN PARK</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																								
W-256 70 5987					CERTIFICATE OF DEATH X					REG. NO. 70 5987														
1. NAME OF DECEASED (Type or Print) <b>Joseph A. Wisomierski (Wiesner)</b>										2. DATE AND HOUR OF DEATH <b>June 8, 1970</b>					M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>														
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 So. Balto. Gen. Hosp.</b>										C. CITY OR TOWN <b>224 Doris Ave.</b>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
										E. STREET AND NUMBER <b>Brooklyn Park</b>														
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1891</b>		9. AGE (In years last birthday) <b>79 yrs.</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Maritime Loading</b>					11. BIRTHPLACE (State or foreign country) <b>Poland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>									
13. FATHER'S NAME <b>Unknown</b>										14. MOTHER'S MAIDEN NAME <b>Unknown</b>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs. Helen Butler</b>					ADDRESS <b>Same</b>									
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarct</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>arteriosclerosis</b>										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis</b>					(B) DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis</b>					(C) DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerosis</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																								
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <b>March 19 63</b> to <b>May 11 1970</b> , that (I) (we) last saw the deceased alive on <b>5-11 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <b>Eugene Schnitzer</b>										Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>June 9, 1970</b>									
23C. PHYSICIAN'S NAME (Type) <b>Eugene Schnitzer M.D.</b>										23D. ADDRESS <b>3904 S. Hanover St. Balto. Md.</b>														
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>June 11, 1970</b>					24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cem.</b>					24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>									
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>					25C. FUNERAL DIRECTOR <b>George J. Gonce</b>					ADDRESS <b>4001 Ritchie Hwy.</b>									





## FUNERAL DIRECTOR: IMPORTANT

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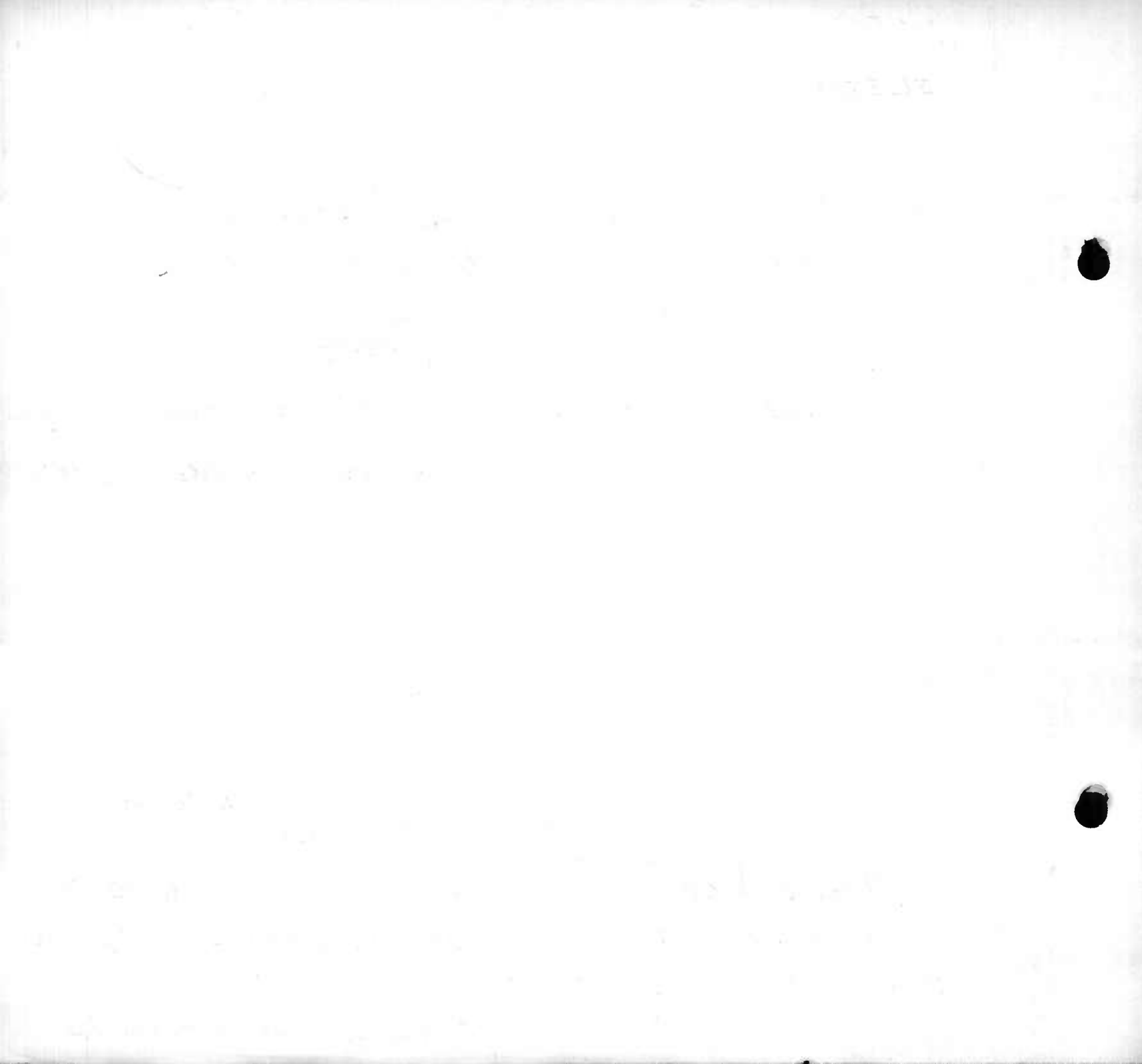
B-300		70 5988		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 5988	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Albert Raidt, Jr.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>6/18/70 11:50 A.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		E. STREET AND NUMBER 3316 BRENDAN AVE. 21213	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/07/08	9. AGE (in years last birthday) 61	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT RAIDT				14. MOTHER'S MAIDEN NAME ROSE SAUER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-5997		17. INFORMANT Mrs. Regina Raidt, 3316 Brendan Ave. 21213			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory arrest 15 min</u> (B) <u>Myocardial infarction</u> 15 min (C) _____ DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>70</u> to <u>6/18</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/18</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William L. Horvath M.D.</u>				23B. DATE SIGNED <u>6/18/70</u>		23C. PHYSICIAN'S NAME (Type) WILLIAM L. HORVATH M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6/11/1970</u>		24C. NAME OF CEMETERY OR CREMATORY Moerland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1970		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR Schimunek Funeral Home-3331 Brehms Lane		ADDRESS 21213	



# FUNERAL DIRECTOR: IMPORTANT

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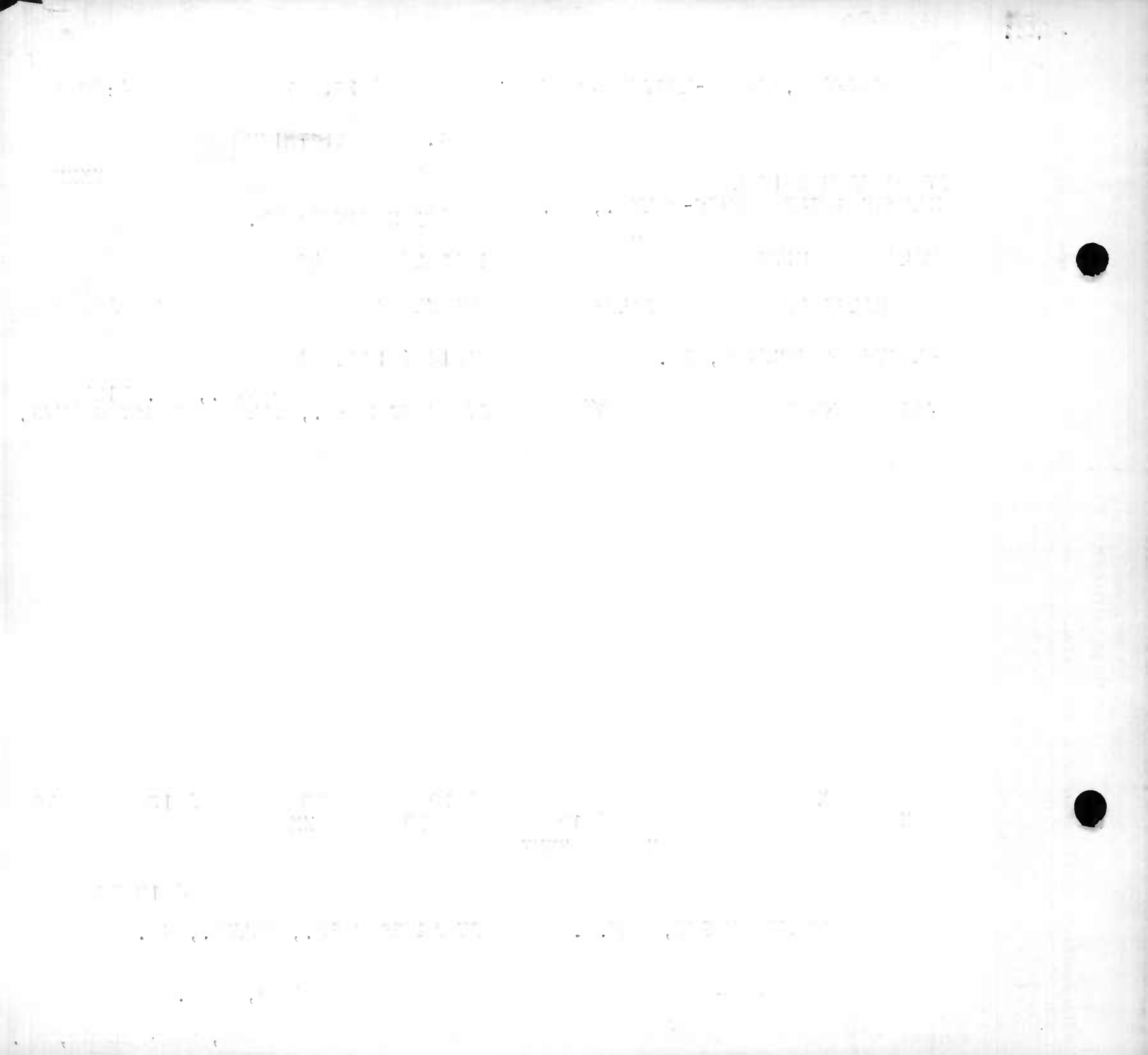
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5989</span>	
BIRTH NO. <span style="float: right;">70 5989</span>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type and last) <b>ELIZABETH DISNEY</b>			2. DATE AND HOUR OF DEATH <b>6-10-70 11 20 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALT</b> C. CITY OR TOWN <b>BALT</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>6-24-97</b> 9. AGE (In years last birthday) <b>72</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		
11. BIRTHPLACE (State or foreign country) <b>MD</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>THALES DISNEY</b>			14. MOTHER'S MAIDEN NAME <b>TURNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI + WWII</b>			16. SOCIAL SECURITY NO. <b>214-01-7647</b>		
17. INFORMANT <b>WIFE</b>			ADDRESS <b>ETHEL DISNEY SAME</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL HEMIPARESIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-10-70</b> 19 to <b>6-10-70</b> 19 that (I) (we) last saw the deceased alive on <b>6-10</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank Lou...</b>			23B. DATE SIGNED <b>6-10-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>F. X. CARROLL</b>			23D. ADDRESS <b>3201 N CHARLES BALT, MD</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/13/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>	
24D. LOCATION <b>Balt.</b>		24E. (City, town, or county)		24F. (State) <b>MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 18 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>		25C. FUNERAL DIRECTOR <b>C. S. MacNabb</b>	
25D. ADDRESS <b>301 Frederick Rd</b>					



# FUNERAL DIRECTOR: IMPORTANT

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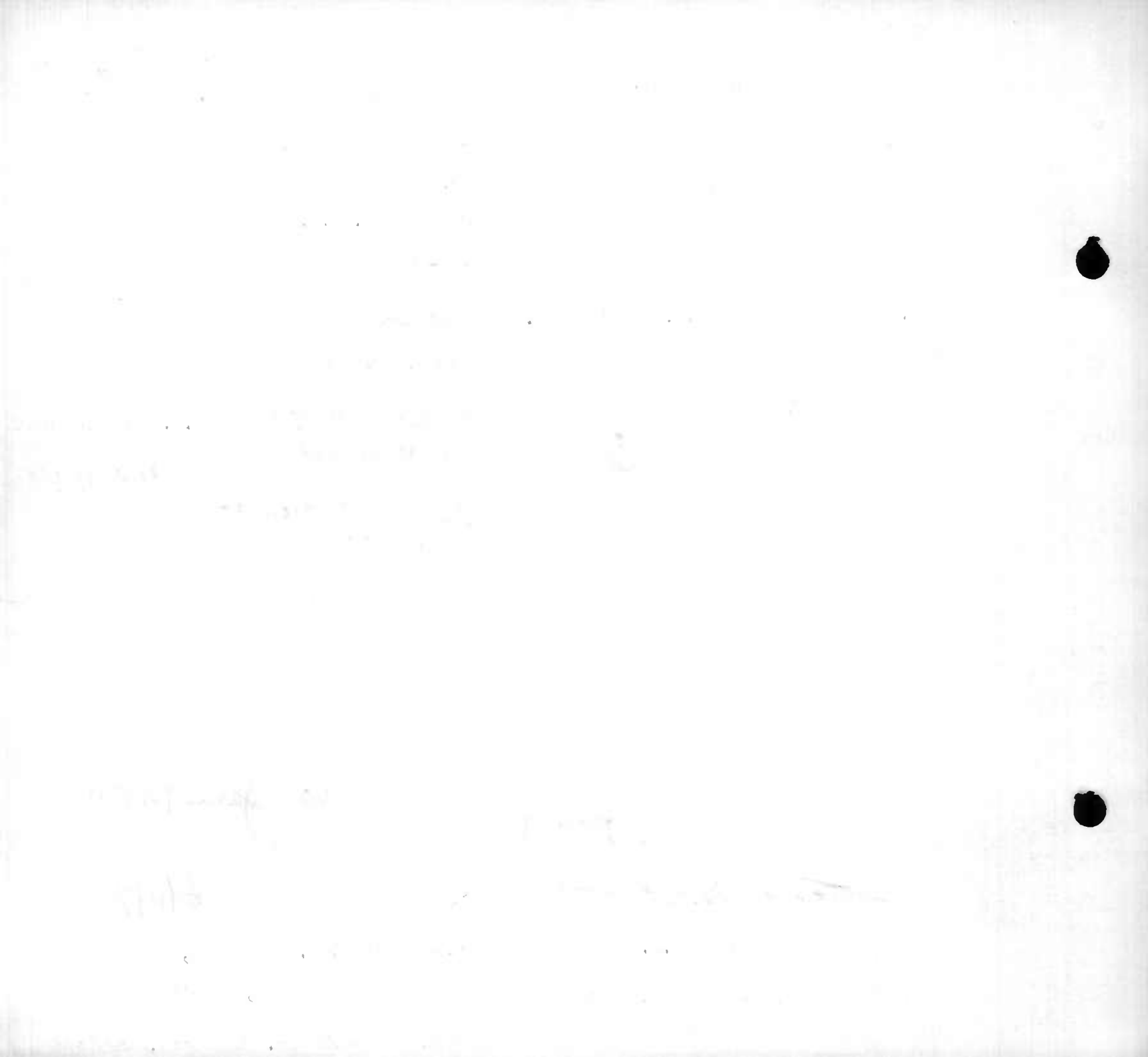
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
1-250 70 5990		70 5990		
1. NAME OF DECEASED (Type or Print) <b>JACKSON, JR -LESTER ANDREW</b>		2. DATE AND HOUR OF DEATH <b>6 10 70 4:40 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES-BALTO., MD.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>APINE ARUNDEL</b> C. CITY OR TOWN <b>LINTHICUM</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XXXX</b> E. STREET AND NUMBER <b>403 HOMEWOOD RD.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 22 25</b>	9. AGE (In years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>LESTER A JACKSON, SR.</b>		
14. MOTHER'S MAIDEN NAME <b>MAMIE (RIGGLER)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW 2</b>		
16. SOCIAL SECURITY NO. <b>219/18/4869</b>		17. INFORMANT <b>BALTO., MD. 21229</b> <b>ST AGNES HOSP., WILKENS &amp; CATON AVES.</b>		
18. CAUSE OF DEATH <b>347.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Decombrate</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>increased intracranial pressure</b> <b>Unknown</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>epileptic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 10 19 70</b> to <b>6 10 19 70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 10 19 70</b> and that <input checked="" type="checkbox"/> (our) apinfan death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE <b>Howard Moses M.D.</b>		23B. DATE SIGNED <b>6 10 70</b>		23C. PHYSICIAN'S NAME (Type) <b>HOWARD MOSES, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>6/13/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>
24D. LOCATION (City, town, or county) <b>Elkridge, Md.</b>		24E. FUNERAL DIRECTOR <b>Singleton Funeral Home, Glen Burnie, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 5991	
G-453 70 5991				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Ernest A. Glantz</b>			2. DATE AND HOUR OF DEATH <b>June 10, 1970. 8 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Long Green Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>District Of Columbia</b> B. COUNTY <b>V-48</b> C. CITY OR TOWN <b>Washington</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6011 4th St. N.W.</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-89</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engraver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alexander Glantz</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>			
16. SOCIAL SECURITY NO. <b>WW 1</b>		17. INFORMANT <b>Mr Joseph Levin 1511 K St. N.W. Washington DC</b>			
18. CAUSE OF DEATH <b>437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Generalized arteriosclerosis</b> (A) IMMEDIATE CAUSE <b>Due to, or as a consequence of:</b> <b>Senility - due to Cerebral ischemia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Many years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 9 1970</b> to <b>June 9 1970</b> and that (I) (we) last saw the deceased alive on <b>June 9 1970</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George McLean</b>				23B. DATE SIGNED <b>6/11/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>George McLean M.D.</b>				23D. ADDRESS <b>Medical Arts Bldg. Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/12/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Baltimore, Maryland</b>			





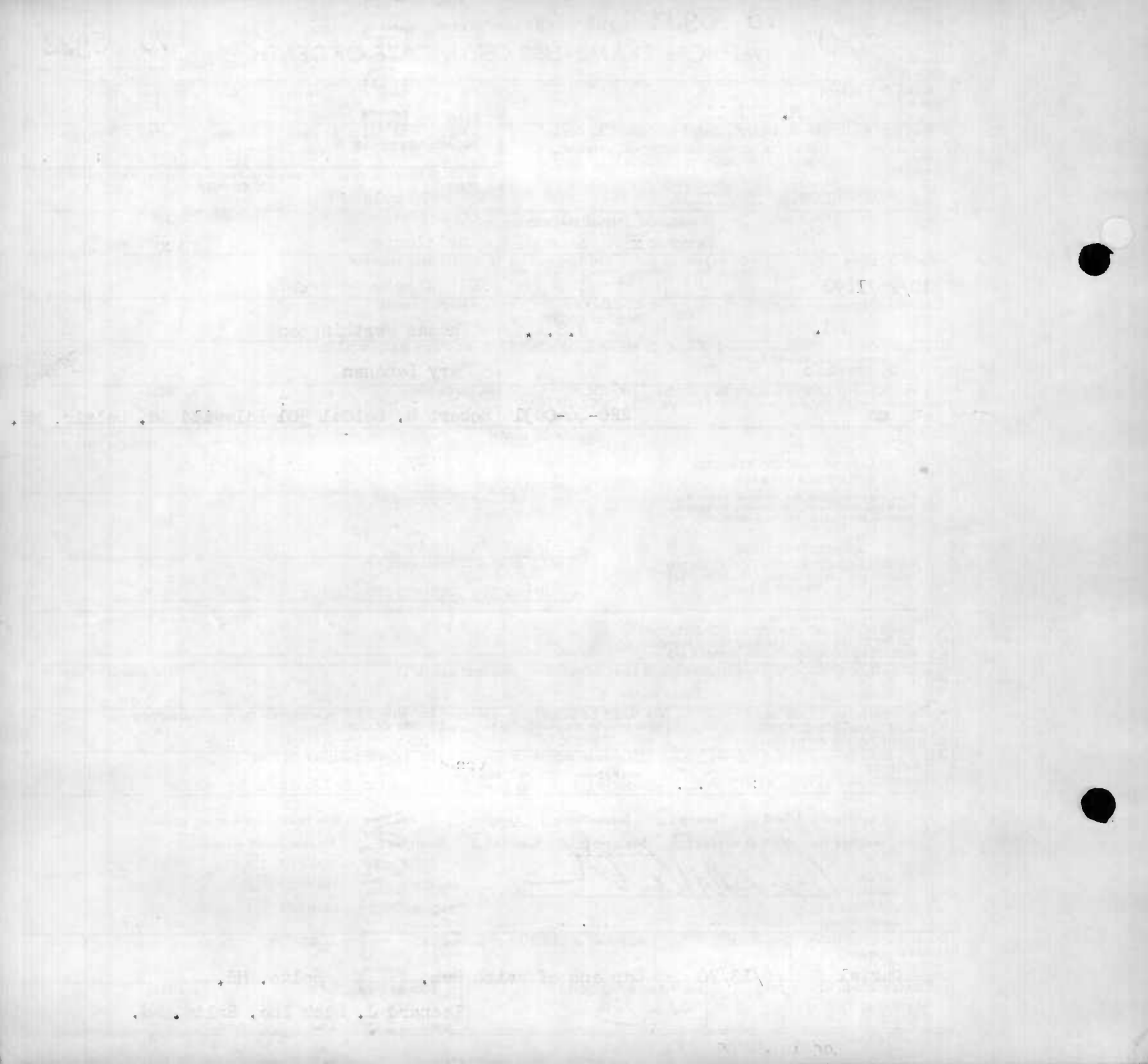
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 5992

BIRTH NO.

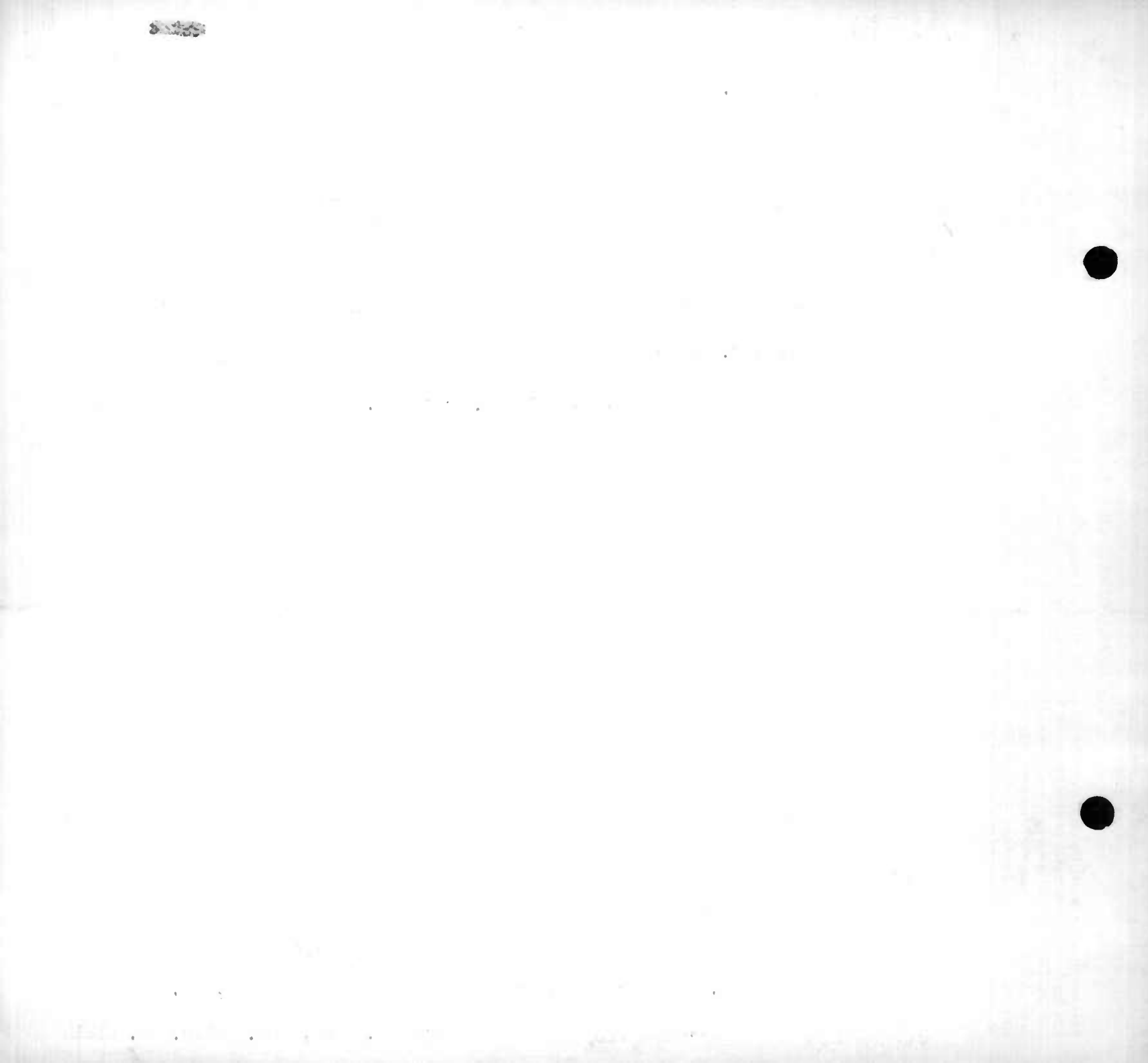
1. NAME OF DECEASED (Type or Print) <b>ANN M. SEIDEL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>June 8, 1970</b> 4:40 P. M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10/26/1898</b>		10. AGE (In years lost birthday) <b>71</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Mary Lanahan</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>220-46-0831</b>	
18. INFORMANT <b>Robert W. Seidel</b>		ADDRESS <b>501 Idlewild Rd. Belair, Md.</b>	
19. <b>E 880 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Massive pulmonary thromboembolism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Phlebothrombosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Multiple traumatic injuries</b>	
20A. DATE OF OPERATION <b>6-2-70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>6-2-70 10:00 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>5612 Birchwood Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Subject fell down basement steps</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>6/10/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/13/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Gabley</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 5993</span>	
T-525 70 5993				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HERBERT S. Townsend</u>		2. DATE AND HOUR OF DEATH <u>6/10/70</u> <u>3 45 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>		5. CITY OR TOWN <u>BALTO</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>HARBOR View NEC</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>M</u>		7. RACE <u>White</u>		8. DATE OF BIRTH <u>3/31/83</u>	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>87</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Master Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James P. Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4429</u>		17. INFORMANT <u>Mr. Andrew W. Townsend</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Branchogenic Carcinoma one year</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>chronic obstructive Pulmonary disease</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-3-</u> <u>1969</u> to <u>6-10-</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>6-10-</u> <u>1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook M.D.</u>		23B. DATE SIGNED <u>6-10-70</u>		23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/13/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



**BALTIMORE CITY HEALTH DEPARTMENT**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CORINE ANDERSON Sewell</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>June</b> Day <b>11</b> , Year <b>1970</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1651 N. Fremont Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>11</b> , Year <b>1970</b> Hour <b>12:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sep 1907</b>		E. STREET AND NUMBER <b>1651 N. Fremont Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		15. MOTHER'S MAIDEN NAME <b>Louise</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr Sylvester White</b>		ADDRESS <b>602 Collect St</b>	
19. CAUSE OF DEATH <b>571.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>June 11, 1970</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>6/15/70</b>	<b>Mt Auburn Cemetry</b>	<b>Baltimore Md</b>
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
<b>JUN 12 1970</b>	<b>Robert E. Taylor</b>	<b>Adolphus Halstead</b>	<b>1206 W North Ave</b>

Coded to last no. on Tremont ave.  
Could not find accurate address.

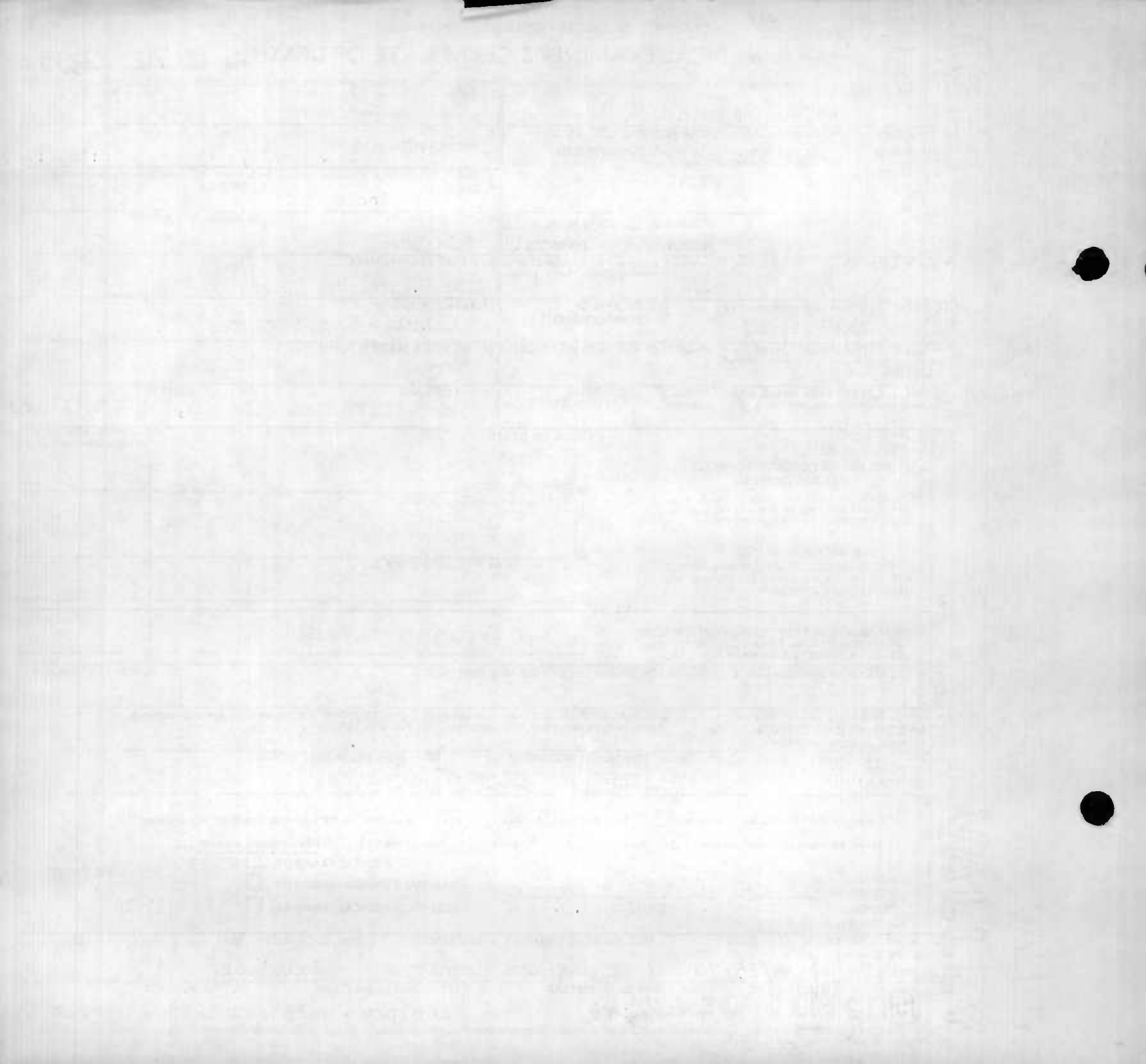
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 5995

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLAUDIA JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 10, 1970 3:15 A.M.	
6. SEX Female		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH		10. AGE (in years lost birthday) 53	11. BIRTHPLACE (State or foreign country) Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charlie Washington	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		15. MOTHER'S MAIDEN NAME Sara	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT Miss Willie Mae Johnson, 724 N Gilmore
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty Metamorphosis of Liver		CAUSE OF DEATH Subdural Hematoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 1970 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1131 N. Stricker Street		22F. HOW DID INJURY OCCUR? Subject fell	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/11/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/70	24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	



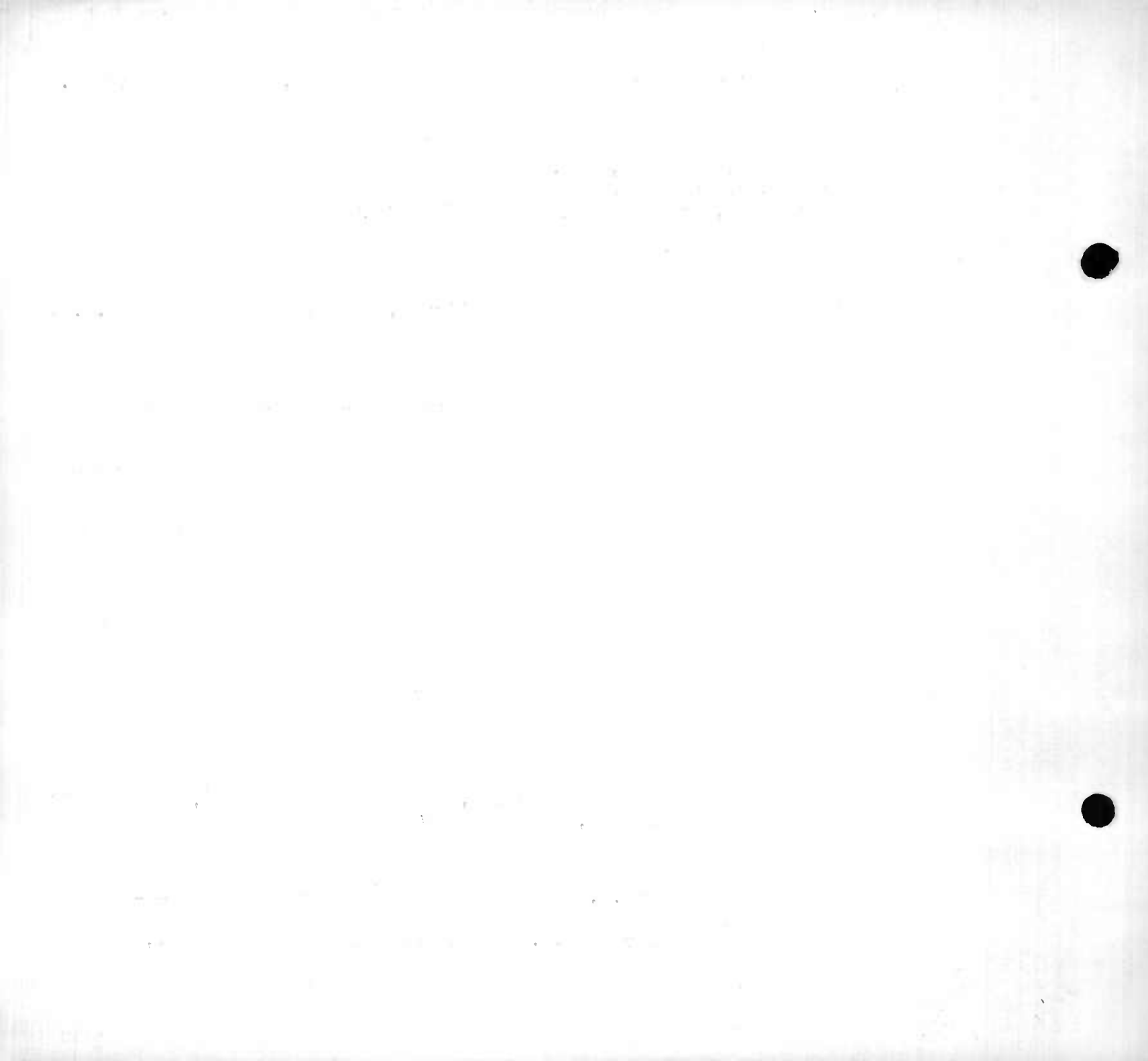




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

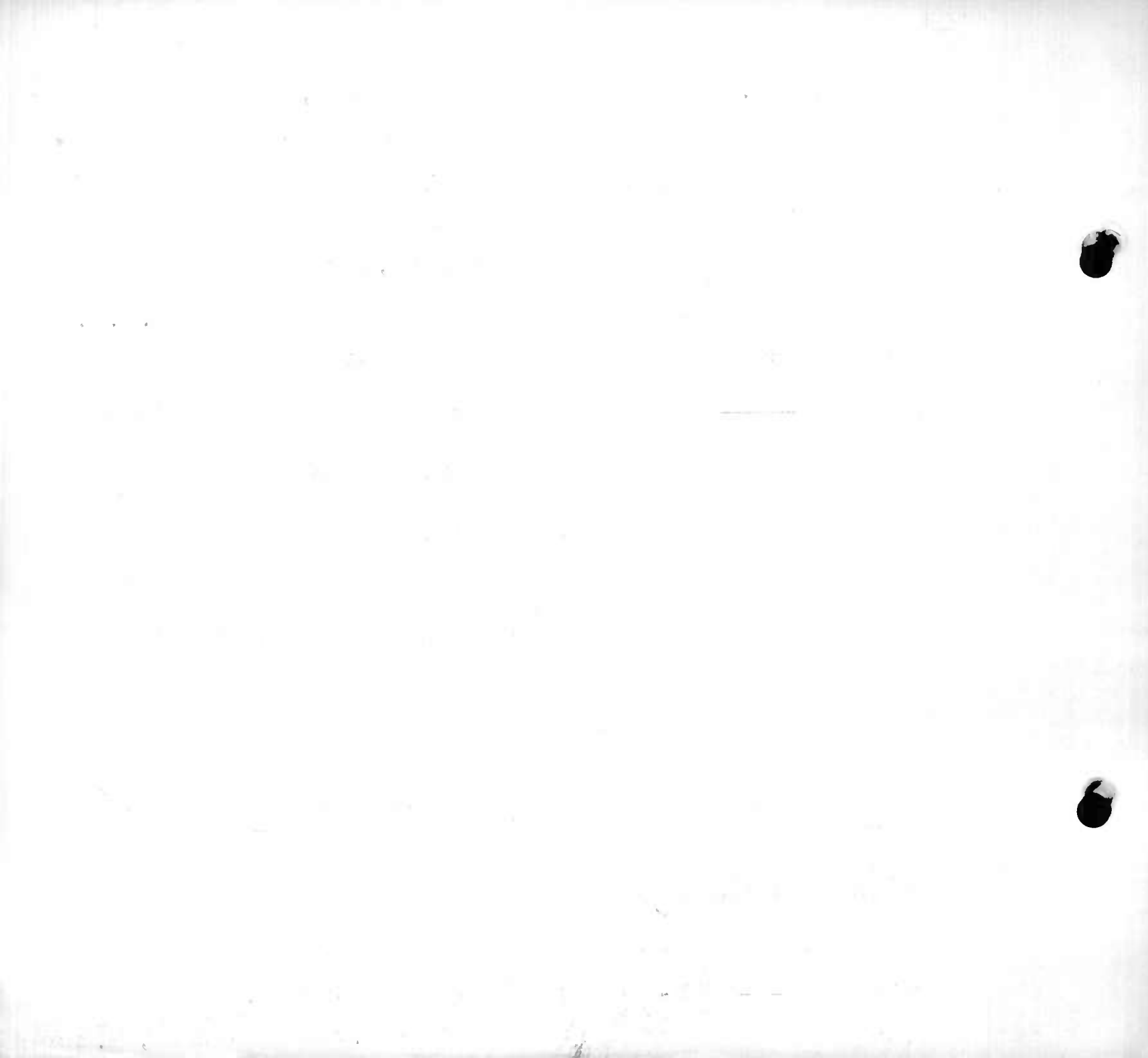
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO. <b>8-5390</b>		5996		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Charles Smith</b>			2. DATE AND HOUR OF DEATH <b>June 8, 1970 2:48 a.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>			A. STATE <b>Maryland</b> B. COUNTY <b>1501</b>		
C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>1353 Stockton Street</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>46?</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Robert Mason- Nephew</b>			ADDRESS <b>SAME</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension, Diabetes, ASH</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>?</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 8, 1970</b> to <b>June 8, 1970</b> that (I) (we) lost saw the deceased alive on <b>June 8, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elijah Saunders M.D.</b>				23B. DATE SIGNED <b>6-8-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ELIJAH SAUNDERS M.D.</b>				23D. ADDRESS <b>1514 Division Street Balto., Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/13/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 1206 W North Av</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 5997</u>	
G-250		70 5997		X	
BIRTH NO. <u>70 5997</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Sarah A. Gahagan</u>			2. DATE AND HOUR OF DEATH <u>June 11, 1970</u> <u>8:54 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>90 The Gould Convalesarium</u> <u>6116 Belair Road</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>21234</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1819 Edgewood Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1891</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
13. FATHER'S NAME <u>Thomas Barlow</u>			14. MOTHER'S MAIDEN NAME <u>M. Maria Hynes</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <u>Joseph Gahagan</u> ADDRESS <u>1819 Edgewood Road 21234</u>	
18. <u>441.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Heart Failure, Chronic Brain Syndrome, Multiple Strokes</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Uremia</u> (B) <u>Renal artery occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Acute abdominal aneurysm</u> <u>Chronic Heart Failure, Chronic Brain Syndrome, Multiple Strokes</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>months</u> <u>years</u>
19A. DATE OF OPERATION <u>6/19/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location).	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/19/70</u> to <u>6/11/70</u> that (I) (we) last saw the deceased alive on <u>6/19/70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>				23B. DATE SIGNED <u>6/12/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERT B. BRADLEY, M.D.</u>				23D. ADDRESS <u>4900 Belair Road 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-15-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. FUNERAL DIRECTOR <u>William E. Johnson</u> ADDRESS <u>8521 Loch Raven Blvd Baltimore, Md. 21204</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1970</u>					

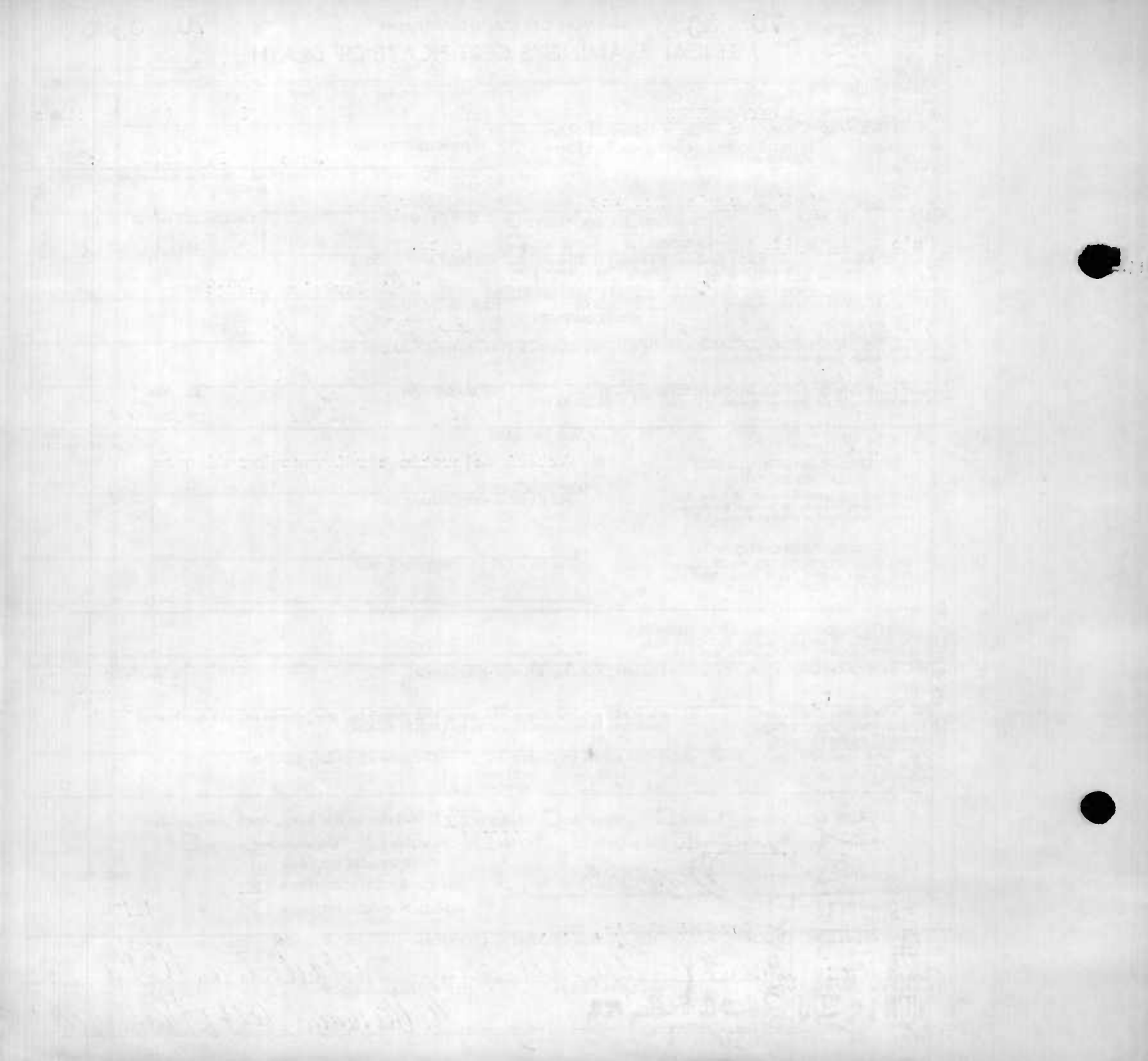


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY HALE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>6 3 70 8:18 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2812 Parkview Terrace</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>June 3, 1970 8:18 a.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>June 5, 08</b>		10. AGE (In years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>Charleston W.Va</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ALTON NOAH</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2702</b>	
15. MOTHER'S MAIDEN NAME <b>Koper</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs Hale</b> ADDRESS <b>Jame</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>6/3/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>June 9-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Edgemoor</b>		24D. LOCATION (City, town, or county) (State) <b>Charleston W.Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUN 12 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>W. Beermann</b>		ADDRESS <b>6067 Hanford Rd</b>	



## CERTIFICATE OF DEATH

REG. NO. 70-5999BIRTH NO. 70-07324

1. NAME OF DECEASED

(Type or Print)

BROWN GIRL A CYNTHIA

2. DATE AND HOUR OF DEATH

May 22, 1970

1:30

A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4940 Eastern Avenue Baltimore, Maryland

BALTIMORE CITY HOSPITALS

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

816 Radnor Avenue

21218

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-1-70

9. AGE (In years  
last birthday)

NB

10. Under 1 Yr. 11. Under 24 Hrs.

Months: Days: Hours: Min.

21

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Cynthia Brown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

BCH: Records 4940 Eastern Avenue  
Baltimore, Maryland 21224

ADDRESS

18. 038.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

septicemiaAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHunknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).Prematurity ~ 30-31 wks

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 5/22 19 70 to 5/22 19 70  
that (1) (we) last saw the deceased alive on 5/22 19 70 and that in (my), (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dale P. Henken MDAttending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5/22/7023C. PHYSICIAN'S  
NAME (Type)

DALE P. HENKEN

MD

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 Eastern Ave.  
Balto. Md. 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

24B. DATE

5-25-70

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

JUN 12 1970

25B. NAME OF REGISTRAR

Robert E. Faber, Jr.

25C. FUNERAL SERVICE

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM CHERRY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 10, 1970 12:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year June 10, 1970 12:40 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>604</b>	
9. DATE OF BIRTH <b>July 20, 1917</b>		10. AGE (In years lost birthday) <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Remedyman</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Lucille Cherry</b>		ADDRESS <b>225 N. Castle St.</b>	
19. <b>345.1</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Subdural hematoma</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>6-10-70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>yard</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>6-10-70 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>225 N. Castle</b>		22F. HOW DID INJURY OCCUR? <b>Apparently hit head during epileptic seizure</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6-10-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT <b>JUN 12 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Miller &amp; Elcker</b>		ADDRESS <b>1129 North Ave.</b>	

